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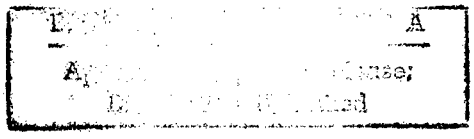
EXAMINING THE IMPLEMENTATION AND OUTCOMES OF THE MILITARY CHILD CARE ACT OF 1989



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EXAMINING THE IMPLEMENTATION AND OUTCOMES OF THE MILITARY CHILD CARE ACT OF 1989

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Prepared for the
Office of the Secretary of Defense

National Defense Research Institute

RAND

PREFACE

This research was sponsored by the Under Secretary of Defense for Personnel and Readiness (Personnel Support, Families and Education). This report is the second of two that explore the implementation of the Military Child Care Act (MCCA) of 1989. The first report, *Examining the Effects of Accreditation on Military Child Development Center Operations and Outcomes,* by G. Zellman, A. Johansen, and J. Van Winkle, was published by RAND in 1994.

The objectives of the research reported herein were fivefold: (1) to assess the extent of implementation of key provisions of the MCCA; (2) to examine the effects of the MCCA on military child development centers; (3) to identify and explain differences in implementation processes and outcomes across the four military services; (4) to examine the extent to which MCCA implementation affected both family child care and youth programs; and (5) to identify policies and efforts that would further improve the delivery of military child care and youth programs.

The report draws on information derived from documents pulled from service headquarters files, data collected from child development program managers who responded to a worldwide mail survey fielded in the spring of 1993, and data collected during site visits to 17 military installations and four major commands from November 1992 through August 1994.

Our findings and the recommendations that follow should help Congress and military policymakers, child development program managers, and installation-level commands better understand the MCCA implementation process and the ways that the legislation has

improved the delivery of child development services for military dependents, their parents, and child development staff. This work should also facilitate our understanding of policy implementation in a military setting, a topic that has received limited attention from implementation scholars. This work will thus contribute as well to our understanding of the implementation of mandates in complex organizations.

The research was conducted within the Forces and Resources Policy Center of RAND's National Defense Research Institute (NDRI). NDRI is a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, and the defense agencies.

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SUMMARY

BACKGROUND AND OBJECTIVES

In November 1989, Congress passed the Military Child Care Act (MCCA) as part of the National Defense Authorization Act for 1990 and 1991. The goals of the new law were to improve the quality and increase the quantity of child care services in the military and to ensure the affordability of care. An additional aim of the act was to standardize the delivery and quality of care across installations and military services, which in 1989 varied considerably. Although the MCCA was to apply to children from birth to age 12, virtually all provisions of the act referred to those who were younger than school age, and nearly all dealt with those receiving care in child development centers (CDCs).

The MCCA's passage precipitated an implementation process that continues today. This process was defined at its outset by two key features of the legislation: (1) immediate, mid-year start-up; and (2) no appropriation. Rapid implementation of an unfunded mandate meant that funds to support implementation had to be taken from other programs, a challenge that elicited strong but considerably different responses across the services.

Some years later, the wisdom of Congress's insistence on the MCCA is generally recognized. This study demonstrates that the MCCA has had a powerful effect on how the military delivers child care to its families. Most agree, despite varying levels of support for its mission, that the MCCA increased consistency across services and installations in the delivery of child development programs, that the

MCCA established strong and specific standards for these programs, and that the law created powerful mechanisms for enforcing them.

These changes did not occur, of course, without a considerable amount of struggle among both supporters and opponents of the act. The process that the passage of the MCCA set in motion is an important one, because it illuminates both the strengths and weaknesses of the legislation and of the system that the legislation sought to change. The purpose of this report is to trace that process and its effects. More specifically, we sought to (1) assess the extent of implementation of key provisions of the MCCA; (2) examine the effects of the MCCA on military CDCs; (3) identify and explain differences in implementation processes and outcomes across the four military services; (4) examine the extent to which MCCA implementation affected both family child care (FCC) and youth programs (YP); and (5) identify policies and efforts likely to further improve the delivery of military child care and youth programs.

STUDY DESIGN

The study design relies on three data sources:

1. Review and abstraction of 336 relevant military headquarters documents;
2. A worldwide mail survey of 245 child development program managers; and
3. Face-to-face interviews with 175 individuals at the Department of Defense (DoD), at the headquarters of each service, at four major commands, and on 17 local installations (including military personnel at all levels, CDC employees, FCC and YP staff, parent users of child care, and kindergarten teachers).

The installation sample was chosen to reflect a range of MCCA implementation and accreditation experiences. Installations were categorized according to the degree of difficulty they had experienced with the overall implementation of MCCA requirements. Installations were also categorized according to the presence (or absence) of at least one accredited center. Those installations with one or more accredited center were further divided into early, middle,

and late accreditors according to the date of accreditation of the first center.

STUDY FINDINGS

Implementation

MCCA implementation can be characterized as a success in terms of both process and outcomes. Most provisions were completely implemented almost everywhere. Only a few provisions fell substantially below this mark by the time of our mail survey in 1993, more than three years after the MCCA's passage. This high level of implementation is not surprising for a number of reasons. Key is the fact that the MCCA was a mandate from Congress. Also important was the nature of the implementing organization: The military is a hierarchical, rule-driven organization that is used to following orders, even if those orders are imposed from outside, disliked, or seen as inconsistent with organizational goals. In addition, the MCCA contained within itself mechanisms that structured implementation of key provisions, a factor that has been repeatedly found to increase the probability of successful implementation. In particular, the system of no-notice inspections, the requirement that a training and curriculum specialist (T&C spec) be on staff in each CDC, and the tying of increased staff pay to completion of required training milestones all contributed to increased quality of care.

Unfortunately, the legislation did not structure implementation to the same degree for all goals and provisions. The other key MCCA goal, increased availability of care (defined as more child care slots), did not benefit from a built-in implementation blueprint; achievement of this goal was more difficult as a result. Nor was the route to implementation of other MCCA provisions as clear. In particular, implementation of the appropriated funds match was difficult and slow. Matching funds in the early years had to come from other programs, hence the match engendered considerable resistance. Compliance with resulting regulations was not uniformly high; implementation was delayed because of service uncertainty about what was or could be included in calculating the match.

Lack of an appropriation combined with a rapid, mid-year start-up complicated implementation in the early years and contributed to very different implementation experiences within the four services. Forced to support the implementation effort with existing funds, services such as the Army, which had been supporting child development at a fairly high level before the MCCA, found the process less difficult and achieved a high level of compliance relatively quickly. The Army's fiscal advantage was further enhanced by the fact that those funds had been supporting a range of efforts that mirrored many MCCA requirements. Consequently, the Army had more resources, and, in some sense, less to do.

In contrast, the Marine Corps lacked resources, existing organizational capacity in the form of child development staff at the headquarters level, and, in some quarters, support for the effort. Implementation there was slower, more contested, and, at the time of our survey, less fully realized.

Nor were all provisions equally implemented. In particular, lack of guidance, limited funds, and resistance all contributed to less-than-uniform implementation of the appropriated funds match across the services. Similarly, one of the few optional provisions, FCC direct subsidies, was largely ignored.

Effects

For the most part, the MCCA has met its three goals: improved quality of care in child development centers, increased availability, and reduced variation across CDCs in quality and affordability of care. The quality goal received the most attention in the legislation and implementing regulations. The MCCA focused on those provisions designed to improve CDC quality, structuring their implementation and building in mechanisms such as inspection reports to monitor their implementation. Consequently, changes in quality are most widespread and apparent.

MCCA quality goals were further enhanced when both the Army and Air Force took the accreditation demonstration program embedded in the legislation very seriously and adopted servicewide policies of

required accreditation.[1] As our earlier report on the MCCA's accreditation demonstration program (Zellman, Johansen, and Van Winkle, 1994) made clear, accreditation by the National Association for the Education of Young Children (NAEYC) is a valuable and powerful tool for improving CDC quality.[2]

In contrast, the MCCA and implementing regulations provided few mechanisms to support the goal of an increased number of slots. Indeed, in some cases a number of efforts to improve quality, such as more rigorous inspections that enforced caregiver-to-child ratios, *reduced* existing CDC capacity.

The goal of more affordable care was expressed in several MCCA provisions. The required 1:1 match of appropriated funds to fee dollars increased subsidization to CDCs, which allowed quality to increase while overall fees did not. A new fee schedule based on total family income was developed by the DoD to make care more affordable. The schedule applied across locations and services, making fees predictable for families facing relocation. The DoD set fees so that they would remain at approximately their current levels. Consequently, the average family would pay approximately the same amount as it did before the MCCA.

Although FCC, which is child care provided by military spouses in military housing, was paid scant attention in the MCCA or the implementing regulations, MCCA-precipitated changes in FCC were expected because of the changes required in CDCs. In particular, decreased CDC capacity and increased appropriated funds support attached to each CDC slot made FCC slots far more appealing to command than they had been in the past. In addition, the DoD made a decision early on in the implementation process to begin to treat FCC much the same as CDCs. This decision reflected DoD's concern with equity of resources across the two types of care.

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[1]The Navy and Marine Corps have also adopted universal accreditation policies since the end of our data collection period.

[2]The National Academy of Early Childhood Programs, a division of the NAEYC, offers the only set of standards for early childhood programs that leads to national accreditation (Hayes et al., 1990). We use NAEYC to refer to both NAEYC and NAECP because the former term is more widely known.

On average, there was a slight increase in the number of FCC spaces, with no significant differences by service in reported changes in the number of full-time FCC slots. Appropriated funds became available to support an FCC coordinator position under the MCCA, and many such positions were established. An FCC coordinator increased FCC legitimacy and stability on many installations that had not had such a position before. This position has also energized recruiting of FCC homes, which has resulted in substantial program expansion on some installations. The inclusion of the FCC program in the MCCA-required inspection and certification process has increased attention to the program as well.

FCC provider training improved in almost half of programs, according to mail survey respondents. Providers now receive more and better training, sometimes from the CDC's T&C spec. Subsidies, although implemented on only a limited basis, have spurred recruitment efforts and encouraged a professional commitment to caregiving.

Virtually all MCCA provisions focused on those who were younger than school age. Any effect on youth programs would be an unintentional consequence of MCCA implementation, thus we did not expect widespread change. Indeed, survey respondents reported few effects on YP. But a few YP respondents to whom we spoke during fieldwork were able to describe concrete benefits that accrued to YP from the MCCA. Most of these concerned improved training for CDC caregivers that was also provided to YP staff. There were also some fieldwork interviewees who told us that YP had benefited from the MCCA in less concrete but nevertheless important ways. For one thing, these people said, the MCCA had underlined the importance of programs for children, the importance of staff training, and the need for vigilance about child abuse.

A few interviewees clarified for us that the lack of change in YP that we found in our survey data was really a lack of *positive* change. Several of those whom we interviewed in the field noted that YP, always in a less favored position than child development programs, had suffered further as a result of the MCCA because far more appropriated funds support was going to CDP than before. This left

administrators less inclined to provide support to YP, since such support was optional, whereas support to CDCs was not.

CONCLUSIONS AND RECOMMENDATIONS

The MCCA has been an extremely effective tool in improving CDC quality. Improved quality everywhere has dramatically reduced the substantial quality differences across CDCs and installations that existed before its passage. Although the effect has been more modest, the MCCA has also resulted in increased availability of care.

The degree of difficulty in implementing the legislation and resulting regulations varied substantially across provisions and services. Those provisions whose implementation process was structured in the law were more easily and fully implemented. Those that relied on DoD and service guidelines were implemented more slowly and less completely.

The effects of the MCCA extended well beyond the CDCs that were the focus of implementation efforts. In particular, the FCC program expanded and became more professional. Perceptions of its value increased as well. Effects on YP were evident but far more mixed. In some cases, the MCCA has had a salutary effect on YP; in others, the effects have been less positive.

Our study of MCCA implementation also revealed a number of strengths and problems in the delivery of military child care. Below, we list our recommendations for ways to build on the enormous progress that the MCCA brought about and to continue to move toward a system of child care that meets the needs of children, families, and the military. Our recommendations to the military are given below.

More Closely Integrate Youth Programs

Child care in CDCs is just one part of military child development programs. These programs include CDCs, FCC, school-age care, and hourly care. In earlier work (Zellman, Johansen, and Meredith, 1992; Zellman and Johansen, 1995), we question whether these elements

cohere into a system of care. What was clear at that time was that the then-current "system" did not extend to YP.[3]

It should. YP needs more appropriated funds, more scrutiny, and an expanded mission that includes recreation but is not limited to that aspect of school-age children's developmental needs. Such a program, organized and run in a way that maximizes both interaction with CDP, would better serve children, would communicate to parents that the military's concern for their children does not stop at age five, and would address the obligation to families that the military has accepted in return for their commitment to putting the military mission above all.

Equalize Family Child Care to the Extent Possible

FCC experienced a key benefit from the MCCA in the form of appropriated funds (APF$) for a program monitor position on each installation with an FCC program. In many cases, this position and its occupant have energized and dramatically improved the program. In addition, a set of FCC-specific training modules was developed by the DoD. These modules are similar in content to the CDC modules but are specific to the FCC environment. Nevertheless, implementation of the act focused heavily on CDCs. This focus reinforced FCC's lesser status in the child development system, a status that reflects commander and parent concerns about limited opportunities for scrutiny, substantial subsidy of CDCs that result in low fees there, and very limited use of authority to directly subsidize FCC providers to equalize fees.

We strongly urge far more widespread use of the subsidization authority permitted under the MCCA. Direct subsidies maximize the advantages of FCC to the system in several ways. First, as we argued in our 1992 report, the substantial subsidization of CDCs in the absence of subsidies for FCC care results in higher fees in FCC. This serves to increase parental preferences for CDC care, reinforcing in most cases a preexisting preference based on the attractiveness and

[3]As discussed in some detail in the report, the Air Force has integrated child care and youth programs under youth flights. The Army has also consolidated child and youth programs.

perceived safety and stability of CDCs. Direct subsidies would serve to decrease the extra costs to parents associated with FCC care. This would make this care more attractive and might reduce the numbers on waiting lists, since some portion of those on waiting lists are there because they prefer CDC care to the FCC care that they are receiving. An active subsidization program would also help to open slots to infants, the parents of whom have the hardest time finding care.[4]

Increase Coordination and Networking Within the Child Development System

Like providers of most services, those who manage and deliver child care in CDCs and in FCC report a sense of isolation and a feeling that they are confronting problems that have been solved elsewhere. This need not be the case for those who deliver child care in the military. A strong, potentially unifying system there could and, in our view, should use its resources to help those delivering child care feel more connected and benefit from the ideas and hard work of others in the system.

Given current downsizing and decreased funds, regional cross-service training represents an opportunity to achieve efficiencies that could compensate to some degree for lack of new resources. Greater standardization of CDPs that has occurred because of the MCCA should facilitate such efforts.

Key to the success of such efforts is building in an expectation that networking should occur, that certain individuals or offices are responsible for ensuring that it happens, and that people throughout the system are expected to be available to each other to share their experiences and their expertise.

Consolidate Responsibility for Children's Programs

On several of the Air Force bases that we visited, we spoke with the Youth Support Flight Chief, who was responsible for overseeing both

[4]Since our fieldwork period, the Navy and Marine Corps have begun to actively subsidize FCC care, which represents a dramatic policy change. The Marine Corps has targeted subsidies to infant/toddler, hourly, extended hours, and special needs care.

child development and youth programs. This position, new in the places we found it, provided a single person as advocate for children and children's programs. Moreover, with responsibility for children's programs vested in a single individual, there was far greater potential for these programs to be seen and treated in a less competitive, more comprehensive way. We encourage the establishment of positions like this that create natural child advocates DoD-wide.

Promote Universal Accreditation

RAND's 1994 report on accreditation concluded that accreditation improves the quality of care provided in CDCs, not only in those centers with lower pre-accreditation quality of care but also in initially high-quality centers. Further, many aspects of the MCCA, including the inspection program, increased caregiver training and salaries, and the hiring of T&C specs, have substantially reduced the incremental costs of accreditation. Consequently, we concluded in our 1994 report:

> Given minimal incremental costs for accreditation and substantial apparent benefits, we conclude that universal accreditation of CDCs is a desirable and achievable goal. Indeed, as accreditations are achieved by initially less-able CDCs, we have every reason to expect that the benefits of accreditation for military children will become increasingly apparent.

As our 1994 report notes, both the Air Force and Army had already adopted universal accreditation policies at that time. Since then, both the Navy and Marine Corps have adopted universal accreditation policies. We support these policies and their rapid implementation.[5]

Create a General Schedule (GS) Caregiver Series and Specific Qualifications

At the time of our survey and visits, it continued to be difficult to hire GS staff. A major reason for the difficulty was the lack of a designated

[5]The 1996 Defense Authorization Bill (P.L. 104-106) mandates accreditation.

series for caregivers in the GS system. Lack of such a series caused both inefficiencies and, at times, a poor fit between new recruits and the demands of caregiving jobs. Poor fits often resulted in higher turnover, as people who did not really wish to be caregivers used the position to move up in the GS system. Before they did so, they probably provided less than optimal care to the children under their charge.

We recommend that the DoD take on the task of creating a caregiver series and specific qualifications in the GS system so that those who wish to pursue caregiving jobs—or to avoid them—can do so within that system. This will increase recruiting efficiency, reduce turnover, and better serve both children and job seekers.

Increase Flexibility in the Use of Appropriated Funds

Difficulties hiring into GS positions had left many CDCs at the time of our fieldwork with a significant amount of unspent appropriated funds. The large amounts of money focused new attention on a problem that needs to be addressed: rigidities in how appropriated funds may be spent. We heard many stories in our travels of appropriated funds requirements that forced CDCs to spend considerably more for a range of equipment and supplies and to receive inferior service on purchases. In addition, we were told in many places that ordering through appropriated funds sources meant long delays in receiving equipment and supplies.

We urge changes that will permit more flexible use of APF$ in CDCs. More discretion in purchasing will save the system considerable money.[6] CDC directors will also benefit from quicker deliveries and less need to guess about what will be needed in the distant future.

Of even greater importance, this increased flexibility should be extended to authority to reimburse NAF$. With appropriate controls, such reimbursement authority will reduce major system inefficiencies and compensate to some degree for lack of new resources flowing into the system.

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[6]Government credit cards have solved some of these problems.

Consolidate Parent Boards

The MCCA's effort to involve parents in the operations of the CDCs that their children attend is laudable. However, the effort is being undermined in some locations by the existence of separate boards for each program, e.g., full-day care, part-day care. We strongly urge that there be one unified parent board on each installation. A unified board will speak for all children and parents and will be more likely to do so in a loud, clear voice.

GLOSSARY

APF$	**Appropriated Funds Dollars** These are taxpayer funds appropriated by Congress.
ASD(FM&P)	**Assistant Secretary of Defense, Force Management and Personnel**
BOS	**Base Operating Support**
CDA	**Child Development Associate** A credentialing program for child care workers.
CDC	**Child Development Center** A centralized location where subsidized child care is provided to military dependents and to some dependents of DoD civilian personnel on a fee-for-service basis.
CDP	**Child Development Program** All child care programs operating on a base, including CDCs, FCC, and efforts supported by supplementary programs and services; youth programs are not included.
CDS	**Child Development Services**

CO	**Commanding Officer** of an installation.
CONUS	**Continental United States**
CPI	**Consumer Price Index**
CPO	**Civilian Personnel Office**
DAT	**Developmental Assessment Team**
DoD	**Department of Defense**
DoDI	**Department of Defense Instruction**
FCC	**Family Child Care** Child care for children of any age provided by military dependents in government housing.
FMP	**Force Management and Personnel**
FTE	**Full-Time Equivalent**
GS	**General Schedule**
HQ	**Service Headquarters** Each of the four services staff headquarters; each office includes CDP staff.
IEP	**Individual Education Plan**
JACM	**Judge Advocate**
MACOM, MAJCOM	**Major Command** A level of organizational structure in the Army and Air Force between headquarters and local installations.
MCCA	**Military Child Care Act of 1989**
MDEP	**Management Decision Package**

MWR	**Morale, Welfare, and Recreation** A system of services that may include child development programs, youth programs, adult recreation, clubs, libraries, and other services.
NAEYC	**National Association for the Education of Young Children** A national organization that accredits civilian and military child care programs through a program component, the National Academy of Early Childhood Programs.
NAF	**Nonappropriated Funds** These are *not* taxpayer funds. These funds are primarily dividends from civilian recreation and/or welfare funds. Parent child care fees are a separate category of NAF$.
NAF Position	**Nonappropriated Funds Position** A civilian patron service employee whose salary comes from NAF$.
NCCS	**National Child Care Survey**
OASD	**Office of the Assistant Secretary of Defense**
OCONUS	**Outside the Continental United States**
O&MMC	**Operations and Maintenance Marine Corps**
OPM	**Office of Personnel Management**
PACAF	**Pacific Air Force**
POC	**Point of Contact**

POM	**Program Objective Memorandum** The military's budget planning documents which describe future funding.
PS	**Patron Service**
RIF	**Reduction in Force**
SALK	**School-Age Latchkey program** An after-school program.
SPS	**Supplementary Programs and Services** The third component of child development programs in some services, with the first two being CDCs and FCC.
T&C Spec	**Training and Curriculum Specialist** A general services employee who supervises staff training and curriculum development in a CDC or in FCC.
TRADOC	**Training and Doctrine Command**
USARPAC	**U.S. Army Pacific**
USDA	**U.S. Department of Agriculture**
USMA	**U.S. Military Academy**
YA	**Youth Activities** Former name of Youth Programs.
YP	**Youth Programs** A program that provides recreation and other services to school-age dependents.

Chapter One

INTRODUCTION AND BACKGROUND

The proportion of active-duty military personnel who are single parents and the proportion of military families in which both parents work have steadily increased. Today, roughly half of all military members have one or more children below school age (Inspector General, 1990). In more than 60 percent of these families, both parents are in the workforce.

Many military spouses are themselves on active duty; 8.9 percent of all active-duty spouses report that their spouses are also on active duty (Department of Defense Health Care Survey, 1992). In addition, the number of single parents in the military has steadily increased (Defense Eligibility Enrollment Reporting System, 1992). These demographic trends have placed pressure on the DoD to expand the availability of child care to military families.

The DoD provides child care as an essential service to maintain readiness, increase productivity, and improve morale. Two settings predominate. The first is the child development center (CDC), which provides care for children on a fee-for-service basis. CDCs offer centralized day care at lower cost than comparable care available in the private sector and provide care not offered by the private sector.[1]

[1]Lower costs are possible because of subsidization of CDCs. The level of subsidization increased under the Military Child Care Act (MCCA) to a point where subsidies were to match parent fees dollar for dollar. The DoD's goal in setting fees (discussed in Chapter Five) was to provide affordable care to military families.

The second type is family child care (FCC).[2] Here, military spouses trained as family day care providers are authorized to care for up to six children in the government quarters that they occupy. Fees are assessed by individual providers. Other arrangements such as before- and after-school programs and parent cooperatives, as well as resource and referral services, are also encouraged.

The most recent data indicate that there are now 831 CDCs and 9,810 FCC homes throughout the world offering care for children as young as six weeks.[3] The capacity for all CDCs and FCC homes (including facilities providing care to school-age children) as of March 1995 was 162,527 (U.S. Department of Defense, 1995).

Despite rapid growth in the number of CDCs, there remained in the late 1980s excess child care demand, which led to concerns about the quantity of care. Incidents of child abuse in several CDCs raised questions about the *quality* of military child care as well. In particular, incidents of child abuse at the Presidio Child Care Center prompted then Congressperson for the Presidio, Barbara Boxer, to ask Beverly Byron, the chairperson of the House Subcommittee on Military Personnel and Compensation, to hold hearings into the circumstances that may have allowed these child abuse incidents to occur.

One of the first issues that emerged in the hearings was high staff turnover because of very low caregiver wages. Another issue that emerged from the hearings was substantial variability across services in the way that child care was operated and managed. For example, there were substantial differences in the level of appropriated funds support; inspection programs ranged from fairly rigorous to nonexistent. The hearings also underlined the inadequacy of appropriated funds support for child care.

As the hearings progressed, Mrs. Byron increasingly came to see child care as a key readiness issue that needed attention. Legislation would be the means to ensure that attention was paid.

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[2]The name for child care provided by military family members in military quarters on base varies across the services. We use the term family child care throughout the report because it is the term now used by the DoD.

[3]This number includes facilities providing care to school-age children.

The MCCA of 1989 was Congress's response to these concerns. The MCCA sought to improve the quantity and quality of child care provided on military installations. An additional aim of the act was to standardize the delivery, quality, and cost of care across installations and military services, which in 1989 varied considerably.

The MCCA relied heavily on four policies to realize the key goals of the legislation. A number of additional policies would support these key goals and address other goals as well. The four new policies included substantial pay increases for those who worked directly with children, with pay raises tied to the completion of training milestones; the hiring of a training and curriculum specialist in each CDC to direct and oversee staff training and curriculum development; the requirement that parent fees (which would henceforth be based on family income) be matched, dollar for dollar, with appropriated funds; and the institution of unannounced inspections of child development centers to be conducted four times yearly.[4] The legislation specified a series of remedies for violations discovered during inspections. It also provided for the establishment of a child abuse reporting hot line. This hot line came to be important as a means of directing inspectors to those CDCs most in need of technical assistance or program improvement.

Additional mandates included the establishment of parent boards in each CDC, the accreditation of 50 CDCs as part of a demonstration program that would assess the value of accreditation by a national, nonmilitary accrediting body, and the establishment of a child abuse reporting hot line. (See Appendix A for a summary of the legislation.)

The framers of the MCCA were concerned only marginally about the lack of appropriation for the MCCA. Many in the DoD understood that an accompanying appropriation was highly unlikely. At the same time, there was hope among some that the mid-year implementation written into the law might force some money out. It did not.

The MCCA was initially opposed by the DoD and by all the services. Their testimony to Congress focused on the lack of need for the

[4]Negotiations with the DoD led to the involvement of DoD staff in inspection visits and in the development of certification standards.

MCCA, given that many similar provisions were already included in a new DoD Instruction that was then being written and was published in March 1989. High-level people in all the services argued that the MCCA would not improve a system that had already recognized its problems and had begun to take steps to change.

The MCCA's passage precipitated an implementation process that continues today. This process was defined at its outset by two key features of the legislation: (1) immediate, mid-year start-up; and (2) no appropriation. Rapid implementation of an unfunded mandate meant that funds to support implementation had to be taken from other programs, a fact that increased opposition to both the MCCA and to child care more generally among some quarters.

The rapid implementation timetable posed substantial burdens on opponents and advocates alike. Implementation milestones written into the law became unrealistic as the legislative process moved less quickly than was anticipated. The realistic but ambitious timeframes and deadlines written into the law became less realistic as time passed. In the case of the deadline for accrediting 50 CDCs, the rush to compliance undermined Congressional intent; the centers chosen for rapid accreditation were those most likely to achieve it. Consequently, preaccreditation quality and accreditation became confounded.[5]

Some years later, the wisdom of Congress's insistence on the MCCA is generally recognized. As we will demonstrate, the MCCA has had a salutary effect on how the military delivers child care to its dependents. Most agree, despite varying levels of support for its mission, that the MCCA increased consistency across services and installations in the delivery of child development programs, and that the law created powerful mechanisms for enforcing high-quality standards.

These changes did not occur, of course, without a considerable amount of struggle among both supporters and opponents of the act. The process that the passage of the MCCA set off is an important one, because it illuminates both the strengths and weaknesses of the

[5]See Zellman, Johansen, and Van Winkle (1994) for more detail concerning the implications of these deadline-driven decisions.

legislation and of the system that the legislation sought to change. In a larger sense, the examination of the implementation of the MCCA sheds light on the process of implementation of a mandate in a complex organization and thus informs our understanding of policy implementation more generally.

STUDY OBJECTIVES

The purpose of this report is to assess MCCA implementation, in terms of both process and outcomes. More specifically, this report seeks to:

1. Assess the extent of implementation of key provisions of the MCCA;
2. Examine the effects of the MCCA on military CDCs;
3. Identify and explain differences in implementation processes and outcomes across the four military services;
4. Examine the extent to which MCCA implementation affected both FCC and youth programs (YP); and
5. Identify policies and efforts that would further improve the delivery of military child care and youth programs.

ORGANIZATION OF THIS REPORT

This report comprises 14 chapters. Chapter Two describes the conceptual model of the implementation process upon which we based our analyses. It also describes our study methods. Chapters Three to Eleven examine the implementation of the nine most important MCCA provisions. Chapter Twelve assesses overall implementation of the MCCA and highlights interservice differences. Chapter Thirteen examines the degree to which the MCCA's key goals were met and also analyzes the effects of the legislation on FCC and YP. Conclusions and recommendations appear in Chapter Fourteen.

Chapter Two

METHODS

Understanding the implementation of the MCCA is a complex undertaking. To aid our understanding and guide the study, we relied on a conceptual framework derived from the policy implementation literature. This framework guided the design of our study and the development of our data collection strategies. Data collection activities were structured to ensure that jointly, they would provide us the information that we needed to be able to use the conceptual framework to draw conclusions about the effect of the MCCA on the delivery of military child care.[1]

This chapter first briefly describes the implementation model upon which the study is based, then explains study data collection methods. It ends with a discussion of the analysis techniques employed.

THE CONCEPTUAL MODEL

Implementation as an area of study was born of a need to understand why policy changes imposed from the top often did not find their way to the bottom of large organizations or, if they did, why they landed there in substantially altered form. This same literature found that organizations tend to overwhelm innovations, emerging unchanged from processes whose goal was explicitly to change them. These findings challenged the assumption that organizational

[1]We use the generic term "military child care" throughout the report to refer to the range of developmentally appropriate activities provided to young children, although the services use different terms to refer to their child care activities.

change is a relatively straightforward process with predictable outcomes.

Researchers set out to understand the implementation process, launching studies in school systems, government bureaucracies, and large industries (e.g., Greenwood, Mann, and McLaughlin, 1975; Wilms, 1982; Langbein and Kerwin, 1985). Jointly, these studies brought some order to the process. Despite variations in how they are described, those who study implementation generally agree that the nature of the new policy, the implementation process, and both the organizational and local context in which the policy is implemented are the most significant contributors to policy change (e.g., Mazmanian and Sabatier, 1983; Goggin, 1987).

From their work, we posit that four main factors influence the outcomes of attempted policy change:

1. The nature of the policy or policy change;
2. The policy context;
3. The implementation process; and
4. The local context for change.

Each of these factors includes a variety of dimensions relevant to policy change in the military. Table 2.1 lists the dimensions of each factor that we believe to be most relevant to a study of the MCCA. Each factor is discussed in more detail below.

THE NATURE OF THE POLICY CHANGE

Implementation itself is best defined as "the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions. Ideally, that decision identifies the problem(s) to be addressed, stipulates the objective(s) to be pursued, and in a variety of ways, *structures* the implementation process" (Mazmanian and Sabatier, 1983, p. 20). Policy analysts often divide the change process into two phases: adoption and implementation. The adoption phase begins with the formulation of a new policy proposal and ends when

Table 2.1

Factors That Affect Policy Implementation and Outcomes

The nature of the policy change	Type of policy instrument
	Validity of causal theory
	Extent of behavioral change required
	Ability of statute to structure implementation
	Initial allocation of financial resources
	Perceived value of new policy to organization
The policy context	The military as an organization
	Changes in the overall scope of the military mission (e.g., downsizing)
	Military relations with Congress
The implementation process	Officials' commitment to statutory objectives
	Organizational capacity and financial commitment
	Pressure for change
	Support for change
Local context for change	Individual leader support
	Level of monitoring

that proposal is formally encoded in a law, regulation, or directive. The implementation phase begins with the formal adoption of the policy and continues at some level as long as the policy remains in effect (e.g., Weimer and Vining, 1992).[2]

Type of Policy Instrument

The design of a new policy and its expression in a policy instrument can substantially affect both the implementation process and the extent to which the policy's original objectives are met in practice. McDonnell and Elmore (1987) describe four generic classes of policy instruments: (1) mandates, which are rules governing the actions of individuals and agencies, intended to produce compliance; (2) inducements, the transfer of funds to individuals or agencies in return for certain agreed-upon actions; (3) capacity-building, the transfer of funds for investment in material, intellectual, or human resources;

[2]Others (e.g., Goggin, 1987) consider implementation to be complete when more than half of the objectives have been met. The military's experience with the MCCA, where new challenges continue to emerge, suggests that this definition may be too limited.

and (4) system-changing, the transfer of official authority among individuals and agencies to change the system through which public goals and services are delivered.

The choice of instrument structures the implementation process to a significant degree. Expected outcomes, costs, and the extent of oversight all vary by type of policy instrument. For example, although mandates seek uniform but minimal compliance, inducements are designed to produce substantial variability in outcomes because there are often many ways to achieve high performance. Mandates require a strong focus on compliance and compliance-monitoring, whereas the implementation of inducements requires oversight but no coercion (McDonnell and Elmore, 1987).

As a law, the MCCA represented a mandate to the DoD. As such, the focus of the implementation effort would be on the monitoring of compliance. Compliance-monitoring by the DoD was reinforced by numerous deadlines in the law for completion of milestones and delivery of reports on implementation progress to Congress. Expectations for innovation or efforts greater than what the law required were minimal.

Validity of the Causal Theory

A policy's successful implementation derives strength from the validity of the causal theory that underlies it. Every major reform contains, at least implicitly, a causal theory linking prescribed actions or interventions to policy objectives. To the degree that there is consensus about the validity of the theory (that is, that most agree that by carrying out the intervention, attainment of policy objectives is likely), policy implementation is facilitated (Mazmanian and Sabatier, 1983).

Underlying the MCCA was the theory that the changes it mandated would improve both the quality and quantity of military child care. The argument that better paid and better trained personnel, more inspections with more consequences, and more resources flowing to child care would improve quality seemed unassailable. For the MCCA, the more crucial issue was the lack of consensus concerning the *value* of this goal, as discussed below.

The causal theory underlying the goal of increased availability was less obviously valid. Indeed, as discussed below, many of the quality improvement activities included in the act and the regulations that followed appeared destined to *reduce* availability. At the same time, the entire issue of availability assumed a secondary status to quality concerns; indeed, the legislation did not contain any specific provisions aimed at achieving increased availability, although it was hoped that the major infusion of appropriated funds would contribute to this end. Consequently, problems with the validity of the causal theory concerning increased availability were minimized.

Extent of Behavioral Change Required

Another key characteristic of a policy innovation is the extent of change required to implement it. Extent can be measured in terms of the size of the target group, the percentage of the population affected, or the number and type of behaviors that must be altered. In general, policies that require less change in terms of numbers and extent are easier to implement (Mazmanian and Sabatier, 1983).

In addition, some changes are inherently more complex than others. For example, a law whose goal is to reduce highway fatalities by lowering the speed limit contains within itself all the information necessary to enable individuals to comply (McDonnell and Elmore, 1987). In contrast, a court order to create equal educational opportunity is less clear-cut. Individuals must not only read and understand the equality standard but must create a plan that translates the goal into required behaviors, a more complex task that may fail because of unwillingness to comply or, more likely, some failure of capacity to do so (McDonnell and Elmore, 1987).

The amount of change required by the MCCA was large in terms of distribution: All installations with a CDC were affected. At the same time, changes were limited for the most part to child development programs, which on most installations constitute only a small fraction of installation activities. (However, certain other operations were also affected directly or indirectly by some of the MCCA's provisions, e.g., general schedule (GS) positions assigned to CDCs reduced the availability of slots in other activities; inspections involved engineering; appropriated funds (APF) match requirements had an effect on many components.)

In a more philosophical sense, the amount of change required by the MCCA was substantial. Many military people saw the MCCA as a major Congressional incursion into the tradition and right of the military to substantial autonomy, a right supported by the courts. Indeed, court deference to the military on matters relating to military service, organization, and personnel has been one of the strongest doctrines in the law (e.g., Jacobson, 1993). In this sense, the actual amount of change required by the MCCA was probably less important than the feeling it engendered in many of substantial loss of autonomy, a feeling that influenced perceptions of the value of the MCCA, as discussed below.

Ability of Statute to Structure Implementation

Implementation guidance is built into some policies, e.g., a reduced speed limit, as noted above. In other cases, guidance is less intrinsic to the policy but may be built in in several forms. Among the most important ways to do so are by clearly ranking policy objectives and by stipulating decision rules for those who will implement them.

A clear ranking of policy objectives is indispensable for program evaluation and for directing the actions of implementing officials. Statements about objectives may also be used as a resource for groups that support the policy objectives. Formal decision rules of implementing agencies, e.g., the stipulation in a statute of the level of support required for a specific action (such as requiring a two-thirds majority of a specified commission for a license to be issued), reduce ambiguity and increase the likelihood that a mandate will be carried out as intended (Mazmanian and Sabatier, 1983).

Congress devoted a good deal of effort in the MCCA to specific implementation guidance for certain provisions of the act. Multiple deadlines, match percentages, and reporting requirements produced widespread accusations of Congressional micromanagement. But these aspects of the legislation created a blueprint for implementation that brooked little (although some) discussion or dispute. This blueprint substantially reduced the ambiguities that often derail implementation efforts (Goggin, 1987).

Other aspects of the act (e.g., fee subsidies, increased availability of care) were accompanied by little or no implementation guidance. As we will show below, this lack of guidance had a negative effect on the implementation and outcomes of these provisions.

Initial Allocation of Financial Resources

As Goggin (1987) notes, lack of financial resources can in some instances be a major contributor to the derailment of an implementation process. The MCCA's status as an unfunded mandate certainly complicated the process.[3] In particular, the lack of an appropriation angered commanding officers (COs) who understood that early implementation would be funded out of their own budgets, which threatened favorite programs and reduced their highly valued autonomy.

At the same time, lack of an appropriation did not in fact derail the process for several reasons. First, appropriated funds existed for other purposes and could therefore *be* reallocated. Second, COs also knew that the Program Objective Memorandum (POM) process would ensure funds for the MCCA over time, so that this situation would not endure forever. Third, COs, who had to take funds for implementation "out of hide," did not perceive that they had an option to do otherwise. Multiple reports to the DoD and Congress, discussed in more detail below, ensured that noncompliance would be public and likely censured.

The lack of an appropriation was, however, a major factor in interservice differences in implementation outcomes. Forced to rely on their own resources at the beginning, those services with a history of strong support for child development had both fewer changes to make and more resources with which to make them. Services with less money and less well-developed programs had to do more with less, which made implementation that much harder.

[3]Unfunded mandates are an issue of considerable concern to the 104th Congress, although the context for these discussions concerns unfunded federal mandates to the states, not the military hierarchy.

Perceived Value of the New Policy to Organization

A key finding of implementation studies is that change is best accepted and institutionalized when at least some people within the organization perceive the need for the change and are persuaded that it is good for the organization and for themselves. Much of the literature on large-scale organizational change focuses on change arising from organizational need, such as declining market share or reduced profits (e.g., Mohrman et al., 1989; Kanter, 1983). In such instances, the likelihood that the change will be embraced is great. Change imposed from without lacks these built-in advantages.

In the case of the MCCA, opinion as to the value of the law differed widely. Those forced to pay for the act by reducing support for other activities—COs and comptrollers—were more likely to oppose its implementation. A cadre of child development professionals supported the act's goals. Key political appointees in the Pentagon, although not uniformly supportive of the act's goals, took on its implementation with energy and resolve, backed by an administration in which the balance of power between civilian and military leadership was clearly tilted toward the former. The relative power of civilians in the Pentagon at that time allowed them to prevail in pushing MCCA implementation despite a very reluctant military side of the house.

Opposition arose as well from those who believed that improvements in the delivery of child care would serve no legitimate need of the military. They argued that while some form of child care might indeed support military goals, substantial and costly improvements in the quality of care already being provided would serve no useful military purpose.

THE POLICY CONTEXT

The nature of the military as an organization, recent efforts at downsizing, and relations with Congress together constitute key aspects of the context in which the MCCA was to be implemented. These aspects of the policy context are discussed briefly below.

The Military as an Organization

The military is viewed organizationally as a hierarchical, rule-driven institution. However, it is also an institution with a strong culture and sense of itself in relation to the external social and political environment. This cultural sense is sufficiently strong that policies that seem at odds with that culture may meet considerable resistance from the top to the bottom of the hierarchy.

The American military is a web of organizational and participant cultures at many different levels, including a participant culture made up of the attitudes and values of those individuals who serve. Military subcultures have been described by Builder (1989), who notes that military organizations and their suborganizations (Army, Air Force, Navy, and Marine Corps) have distinctive cultures that have a significant effect on the way that the organizations operate and react in a variety of situations. Despite this variability across and within services, on balance, the military can be described as an organization that values efficiency, predictability, and stability in operations. This structure is supported and reinforced by organizational and participant cultures that are conservative, rooted in history and tradition, based on group loyalty and conformity, and oriented toward obedience to superiors. Many observers have noted that, to the extent that a conservative military organization values predictability and stability, it is implicitly averse to change, and explicitly averse to change dictated from outside the organization (e.g., Builder, 1989).

Militaries have always seen themselves as somewhat apart from the larger societies that support them and that they are constituted to protect. Part of the separateness stems from the military mission and its burdens. But the American military has, by its rapid rotation of people through assignments and posts and by its substantial forward presence overseas, enhanced that separateness and fostered a separate military family and society.

Key to that separate society has been the notion that military personnel make a far greater commitment to the military than civilian employees make to their employers. In return, the military accepts some heightened responsibility for taking care of its members. If members are expected to put duty before all else at all times, then the military must reciprocate with support and protection unknown

in the civilian world. Because of frequent movement of personnel that leave most without close family members nearby, the need for support of various sorts is greater than it might be in a more geographically stable civilian population. Key among these supports is child care, which is variously described by military personnel as an instrument of readiness, a way of "taking care of our own," a tool to increase total family income by allowing spouses to work, and a quality of life issue (Zellman, Johansen, and Meredith, 1992). These various forces have converged to make the military the major provider of employer-sponsored child care in this country.

As the demographic differences between the American military and the rest of society have been closing during the last decade with increasing numbers of two-career families and the decline of the "officer's wife" as an occupation, pressures to increase the supply of child care have increased.

Downsizing

In response to the end of the Cold War, the military's role and mission were being widely questioned by the end of the 1980s. Drawdowns and reduced installation budgets contributed to an unwelcoming environment for MCCA implementation in many places. In others, expansion caused by closings of other bases created tensions and overtaxing of the troops. As the Marsh Panel recently concluded, the active-duty force is being asked to do more at the same time the overall military is getting smaller (Marsh, 1995).

These reduced military budgets have created considerable anxiety among military personnel. Many believe that with base closings, drawdowns, and reductions in benefits, the military has violated the psychological contract between the organization and its members (Rousseau, 1989). The resulting anger and resentment have made some members disinclined to support programs such as child care that they view as costly, elitist, and tangential at best to the military mission. This has become even more the case as growing numbers of single parents rely on military CDCs for child care. Although most are not as outspoken as a high-level Marine Corps officer, who argued recently in the press that single parents do not belong in the military, his argument received a sympathetic hearing in many quarters and particularly at higher levels of the military.

Military Relations with Congress

The military is highly averse to change imposed by Congress for several reasons. First, such change threatens to undermine military autonomy. Autonomy is highly valued and considered essential to meeting the military's key mission. Second, the military believes that Congress lacks the understanding necessary to make policy for the military. Such a belief is buttressed by the fact that for the first time, the majority of the members of Congress who now serve on military-related committees lack military experience. Finally, change imposed from the outside is perceived as criticism, and criticism from an insufficiently informed source is particularly unwelcome. A Congressional mandate, and one that was initially opposed by the DoD and all the services, would be greeted with suspicion at best. The level of detail in the MCCA contributed to feelings of opposition and imposition.[4]

THE IMPLEMENTATION PROCESS

Key factors that determine the speed and success of the implementation process include officials' commitment to statutory objectives, organizational capacity, pressure for change, and support for change. Each of these factors is discussed briefly below.

Officials' Commitment to Statutory Objectives

Mazmanian and Sabatier (1983) note the importance of committed implementors as driving forces for policy change. Conversely, leaders uncommitted to a new policy may restrain change efforts. Indeed, they suggest that the inability of policymakers or organizational leaders to choose implementors is a major factor in implementation failures. If implementors cannot be replaced, and often they cannot, the leader's job is to change the perceptions of the implementors concerning the likely outcomes of the new policy. If implementors come to view the new policy as consistent with their own self-interest (Mazmanian and Sabatier, 1983) and with orga-

[4]The military's antipathy to change imposed by Congress is similar to resistance by the states to mandates imposed on them by the federal government (Stoker, 1991).

nizational culture (Schein, 1987), they will be far more likely to support the new policy and act in ways that enhance its implementation.

We expected commitment to the MCCA to vary substantially as a function of organization position and service. Those directly responsible for implementation—caregivers and CDC directors—would likely find MCCA-induced changes personally and professionally rewarding. Higher pay and lower ratios would make the job more rewarding. More training would also contribute to higher-quality caregiving. In contrast, we expected that COs, who had to fund MCCA implementation by reducing support for other activities, would not be as supportive.

We also expected variation in commitment to MCCA implementation across services. Using pre-MCCA funding for child care as an indicator of commitment to child care, we expected considerable variation in the speed and enthusiasm with which implementation would be undertaken. Those services with greater commitment to child care in general and to the MCCA in particular would be expected to implement the provisions of the act more quickly and enthusiastically than those services with a lesser commitment.

Organizational Capacity and Financial Commitment

Goggin (1987) and others note that the capacity of an implementing unit to carry out the changes required can substantially affect the implementation process. Different aspects of capacity, including resources, staff, and slack, may work together or compensate for each other during implementation.

As MCCA implementation got under way, preexisting differences across services in organizational capacity both within and outside child development seemed likely to influence the implementation process. The Army was generally agreed to be best prepared to take on the MCCA for several reasons. Fairly generous funding and staffing of child development programs, including employment of Training and Curriculum specialists (T&C specs), had created a large child development system in which there were no profit expectations. A service ethos that focused concern on family well-being (Builder, 1996) ensured necessary financial support for MCCA

implementation. A fairly active inspection program had provided staff with some understanding about child care quality.

In some contrast, the Marine Corps had been running a far smaller and less well-funded system. A service ethos that stressed doing more with less (Builder, 1996) was likely to limit financial support for MCCA implementation. The inspection program that the DoD required was not operating, largely due to lack of capacity. Consequently, Marine Corps child development staff had not had the opportunity to learn about or experience quality assessment processes.

These substantial differences in capacity (with the Navy and Air Force arrayed in between) reflected both fiscal realities and differences in organizational commitment to child development programs.

Pressure for Change

Research on regulatory policy has demonstrated that targets of mandates incur costs from complying or from avoiding compliance. The choice they make to comply with the mandate or attempt to avoid doing so is based on the perceived costs of each alternative. Targets decide whether or not to comply by calculating two kinds of costs: (1) the likelihood that the policy will be strictly enforced and compliance failures will be detected and (2) the severity of sanctions for noncompliance. If enforcement is strict and sanction costs are high, compliance is more likely (McDonnell and Elmore, 1987).[5]

To increase the likelihood of compliance with a mandate, the implementation plan must include certain and severe enforcement mechanisms and sanctions (Goggin, 1987) that lead targets to assess the costs of noncompliance as high and thus increase the likelihood that they will choose to comply. Such a plan is likely to create an adversarial relationship between initiators and targets, particularly

[5]Targets essentially employ an expectancy value calculation in making these decisions. Such calculations are a key component of models such as the Health Belief model (Janz and Becker, 1984; Rosenstock, Stecher, and Becker, 1988) that seek to predict the likelihood that an individual will undertake a particular preventive measure, such as contraceptive use (e.g., Eisen and Zellman, 1992).

when targets do not support policy goals (McDonnell and Elmore, 1987).

The MCCA, as discussed above, included within it considerable pressure for change. In particular, inspection requirements made it clear that compliance failures would be discovered and addressed in quite public ways. The presence of DoD staff ensured that inspections would be taken seriously. The quarterly inspection schedule and severe sanctions for compliance failures (CDC closure and required reporting of all closures to Congress) combined to produce both a high likelihood of discovery of compliance failure and a costly consequence; both of these factors increased the pressure to change. A lack of waivers on wage increases or fees made the implementation of these components clear and likely.

Support for Change

Along with pressure to comply, policy mandates and their implementing regulations should provide support for implementation. Key aspects of support are a system of rewards that recognize compliance efforts and allow room for bottom-level input into the process.

A set of rewards for any movement that supports implementation of the policy is key. The goal of these rewards is for individuals to perceive that their own self-interest lies in supporting the change. Such beliefs represent the energizing force for successful implementation of change (Mazmanian and Sabatier, 1983; Levin and Ferman, 1986).

The MCCA was, not surprisingly, silent concerning support for change, as mandates generally are. We therefore looked for evidence for support for change in abstracted documents, survey data, and fieldwork interviews, as discussed below.

THE LOCAL CONTEXT FOR CHANGE

Individual Leader Support

The MCCA, imposed by Congress and implemented quickly without an appropriation, was likely to find a rather hostile reception on the ground, at the installation level. Yet, even in this conflicted organi-

zational context, individual leaders arose in many places who used their position to support MCCA implementation. Although the basis for their support varied (some had spouses concerned about child care; some believed their job was to make things happen), their support contributed to successful implementation when they acted as "fixers" (Levin and Ferman, 1986), repairing the implementation process and smoothing its edges.

Level of Monitoring

The nature of the MCCA mandate and of the military's hierarchical structure meant that implementation of key components of the MCCA at an acceptable level of compliance was in some sense never in doubt. Provisions built into the legislation, particularly inspection requirements, created (in some services) and strengthened (in the others) a mechanism to ensure compliance. Particularly with regard to the more measurable and quantifiable aspects of the MCCA such as fees and wages, where waivers were not permitted, the legislation created a way to ensure its own implementation.

In contrast, the implementation of many of the components of the MCCA that arguably mattered most, such as accreditation and the APF$ match, were not ensured. Personal monitoring of their implementation by key leaders was a major factor in cutting through the resistance engineered by the mid-year appropriation-free law in many places, as discussed below.

STUDY DESIGN, DATA COLLECTION STRATEGIES, AND ANALYTIC METHODS

This study had two broad objectives. The first was to examine and understand the MCCA implementation process. The second was to analyze the effects of that process on how child care is delivered in the military. To achieve both sets of objectives, we needed a study design that ensured that we would collect critical information about the implementation process and that we could relate process to outcome data. To study the implementation process, we developed a conceptual framework, as noted above. This framework was derived from previous implementation studies. The study design, driven by

our conceptual framework, would capture relevant dimensions of the implementation process.

Our assessment of the effect of the MCCA relies on data collected after the start of implementation because the study was not undertaken until after the implementation process had already begun. However, retrospective information about pre-MCCA conditions was obtained from those interviewees who were in a position to have observed changes brought about by the MCCA. Although such retrospective data necessarily suffer from some recall bias, they do provide a sense of the magnitude and nature of change. Assuming that the recall bias does not vary across services or interviewees, our data allow us to assess both current outcomes and the magnitude of change brought about by the MCCA.

DATA COLLECTION STRATEGIES

As discussed above, policy implementation is a complex process that may be precipitated by actions outside an organization that filter down from the top, but that also depends heavily on the attitudes and behaviors of those at the bottom of the implementing organization. Top-down and bottom-up implementation can both be traced through formal organizational processes, such as regulations and rules concerning the new policy and its implementation, and through the attitudes and behaviors of key actors at all levels of the organization.

To capture these two key aspects of organizational change—top-down and bottom-up implementation—we devised a data collection strategy that allowed us to assess the change process from these very different perspectives. It included three data collection activities, as suggested by Goggin (1987). These data activities included:

1. Review and abstraction of 336 relevant military headquarters documents;
2. A worldwide mail survey of 245 child development program managers; and
3. Face-to-face interviews with a total of 175 individuals at the DoD, at four major commands, and on 17 local installations (including

military personnel at all levels, CDC employees, parent users of child care, and kindergarten teachers).

The military documents provide a window on the top-down aspects of the implementation process; the worldwide mail survey of child development managers obtains information concerning both the implementation process and the effect of the MCCA at the ground level from those most closely involved in the implementation process; and the installation visits and interviews examine up close and in greater detail the implementation process and its outcomes at all levels of local installations.

MILITARY DOCUMENT ABSTRACTION

First, military documents gathered from service headquarters were read and analyzed to obtain information about implementation schedules, the development of regulations, key issues and problems, and important implementation milestones and outcomes. These documents included instructions, regulations, memos, messages (a brief, less formal version of a memo), letters, otherwise unspecified facsimiles, briefing or other charts, and other documents. This activity provided rich information about top-down implementation and formal communication of requirements, expectations, and compliance.

To obtain this information, senior project staff pulled and copied key materials from the headquarters files of each service's child care manager. Documents eligible for copying were written between November 1989, the date of MCCA passage, and July 1993, the time of our visits. We also interviewed each child care manager about the content of the files and the filing system. This information was intended to help us understand the meaning of missing information, any lack of comparability across services in the type or amount of material in the files, and those aspects of the legislation and implementation process that were the most problematic.

The child care manager in each service graciously opened her files to us. We selected those materials from the headquarters files that concerned key MCCA components and that illuminated key aspects of the implementation process. For the most part, these decisions were made by a single senior project staff member because of the press of

time. However, in some instances two senior staff members discussed the relevance of a particular document and reached a joint decision to pull or not to pull the document for copying and abstraction. Altogether, we pulled and copied a total of 336 documents from headquarters files, which represented approximately half of all the eligible materials in the MCCA-relevant files. As shown in Table 2.2, the number of documents selected varied by service.

Documents were read and coded using a precolumned abstraction form that contained 14 items. Coding forms were data-entered and used in the analysis. Three of the most subjective items (purpose, amount of change specified, and relationship to prior documents) were not used in the analyses, as coding of these items was unreliable.[6]

In addition, the content of each document was qualitatively analyzed for key material not likely to emerge in the more structured coding effort. This qualitative analysis included such things as evidence of organizational support for MCCA, implementation strategies, and financial burden of MCCA implementation.

The document abstraction material presented below is based on both the quantitative data derived from the coding form and from the more qualitative analyses of the documents. Although the selection, coding, and analysis processes rely heavily on researchers' judgments, interrater reliability is sufficiently high, and the results of

Table 2.2

Number of Documents Pulled and Copied, by Service

Air Force	139
Army	68
Marine Corps	38
Navy	91
Total	336

[6]To assess reliability, a second rater coded 34 randomly selected documents representing 10 percent of documents extracted from the records of each service. Average reliability (measured by kappa) (Fleiss, 1981) on the 11 items included in the analyses was 0.82.

the abstraction analyses are sufficiently consistent with results from installation visits and from the mail survey, that we feel confident that the findings are both meaningful and important. Hence, we integrate them throughout the report as an important source of information about MCCA implementation.

Given that the abstracted documents were selected from headquarters files because of their potential relevance to the MCCA, it is not surprising that the largest number (27 percent) were dated 1990, the first full year of MCCA implementation. Twenty-two percent of coded documents were issued in 1991; another 22 percent were dated 1992. There were few 1993 documents; this reflected RAND's mid-year 1993 document collection. These patterns differed to some degree by service.

Both the Marine Corps and the Army issued more abstracted materials in 1990 than in any subsequent year. The Navy issued the most abstracted documents in 1991. The Air Force issued the most abstracted documents in 1992. The Army's rapid response suggests a greater degree of continuity between what went before and MCCA requirements. In addition, higher pre-MCCA funding levels permitted more aggressive early implementation.

WORLDWIDE MAIL SURVEY

The abstracted documents are supplemented by two sources of primary data regarding the process associated with and the outcomes of MCCA implementation. The first is a military-wide self-administered mail survey regarding the implementation of the MCCA. This survey was designed to capture all the relevant dimensions of the implementation process and outcomes, both intentional and unintentional. In addition, questions were asked regarding the situation before the implementation of the MCCA to obtain a sense of the magnitude and direction of change.[7]

[7]We were aware that many respondents would not be able to answer more historical questions. They were encouraged to consult with colleagues about these questions. If there was no one who could answer the historical questions, respondents were asked to leave them blank.

The survey contained a total of 113 questions, most of which were closed-ended, although many questions provided a write-in option. The survey's last question was an open-ended one requesting any comments or suggestions that the respondent might have regarding the MCCA and its implementation.

The survey was developed in consultation with military child development specialists, and field-tested by two child development directors. Customized versions of the survey were developed for each service to make sure that the appropriate terminology was used for each service. The final survey instruments are available upon request from the authors.

The survey was mailed to all installations with a CDC in May 1993. We asked that the survey be completed by the person who was in charge of child development services, the child development program (CDP) coordinator, or the CDP director.[8] Given high rates of turnover in some positions, in the cover letter we told recipients, "if you have not held your job very long or don't know too much about MCCA history for any other reason, we encourage you to ask those who do know to help you complete the questions."

On installations with more than one CDC, we asked for information concerning individual centers as appropriate. A total of 245 installations—80 percent of those eligible—completed the mail survey. The majority of the nonresponses were from installations outside the continental United States (OCONUS), which means that our ability to generalize results to OCONUS is limited. Of the 245 installations that responded to the survey, 80 (approximately one-third) had one or more accredited CDCs. In total, 466 CDCs were represented in the survey sample.

The responses from the mail survey were analyzed statistically, using the software package STATA (Computing Resource Center, 1992). As appropriate, statistical tests of significance (e.g., F-tests, t-tests) were performed. The type of test and the results are noted in the text where relevant.

[8]Fifty-four percent of our respondents were CDP coordinators, 36 percent were CDP directors, and 10 percent placed themselves in an "other" category.

INSTALLATION VISITS

The second primary data source derives from a series of face-to-face interviews conducted with personnel holding a range of relevant positions on a small number of installations specifically picked for the purpose of providing detailed implementation information (see below for a description of the criteria for selection of installations). On each installation, we asked permission to interview a command representative, a representative of the organization in which CDP was located, CDP management and staff (CDP director, training and curriculum specialist, family child care coordinator, caregivers), the youth programs director, and, at a subset of installations, parent users of the CDC and kindergarten teachers.[9]

Before these visits, a semistructured interview form was developed for each respondent category to enable us to obtain information that that respondent was uniquely able to provide because of his or her position. Thus, CDP coordinators and directors were asked about management issues in addition to general questions concerning MCCA-precipitated changes in the provision of care; CDP staff were asked about the changes that affected them in the classroom and how these in turn affected the children with whom they worked. Similarly, budgetary staff were asked about the fiscal effect of the MCCA, and so on for other respondent categories.

Interviews with parents and kindergarten teachers were initially planned during all installation visits. However, the initial interviews with these respondents during six installation visits provided little insight into the MCCA implementation process. As discussed below, kindergarten teachers rarely knew if their students had been in any organized preschool program, so they could not talk about the perceived effect of the MCCA or of accreditation. Parents, although slightly more knowledgeable, could only rarely distinguish MCCA-

[9]In most cases, the CDP managers completed our mail survey in addition to an on-site interview. We did this so that the mail survey sample would include as many installations as possible. Although there was some overlap between mail survey and interview questions, the latter focused on unique aspects of the particular installation's experience with MCCA implementation, including relationships with superiors, the effect of local funds availability, and the effect of pre-MCCA facility, program quality, and history on the MCCA implementation process.

based and accreditation-based changes. These interviews were therefore discontinued.[10]

The interview notes were transcribed after each installation visit and then coded using a set of descriptive, interpretive, and explanatory codes (Miles and Huberman, 1984). When all notes were coded, the data were searched for instances of both verification and nonsupport of apparent patterns (Miles, 1990). Conclusions were drawn on the basis of those findings that appeared consistently in the data. These analyses were then compared to the findings derived from the mail survey and from the review of documents.

SELECTION OF THE INSTALLATION SAMPLE

The installation sample was chosen to reflect a range of MCCA implementation and accreditation experiences.[11] The selection process was stratified by service on the basis of information obtained from child development specialists in each service headquarters. To do this, installations were categorized according to the degree of difficulty (easy, average, difficult) that they had experienced with the overall implementation of MCCA requirements. Installations were also categorized according to the presence (or absence) of at least one accredited center. Those installations with one or more accredited center were further divided into early, middle, and late accreditation categories according to the date of accreditation. These categories were: (1) before June 1, 1991; (2) June 1, 1991 to December 31, 1992; and (3) after 1992.[12]

The final selection criterion was location. Because the changes occurring in the military at large at the time of sample selection created considerable uncertainty regarding the future of many OCONUS installations, we limited our installation visits to those in the

[10]The number and location of interviews conducted with parents and teachers are listed in Table 2.3.

[11]Accreditation experience was chosen as a stratification variable because the study also included a special component to evaluate the effect of accreditation on child care services and child outcomes. The results of this evaluation are available in Zellman, Johansen, and Van Winkle (1994).

[12]The June 1, 1991, date was a deadline for accreditation of 50 centers DoD-wide, written into the MCCA.

Table 2.3

Installation Visits and Center Status

Installation	No. of Accredited Centers	Total No. of Centers	No. of Parent Interviews	No. of Teacher Interviews
Army				
Fort Belvoir, VA[a]	0	2		
Fort Carson, CO	2	2	3	0
Fort Monroe, VA	1	1		
West Point, NY	0	1		
Stewart Army Air Field, NY	1	1		
Navy				
Annapolis, MD	1	1		
Long Beach, CA	2	3	4	2
Miramar, CA[a]	0	1		
Port Hueneme, CA	2	2	2	1
Marine Corps				
Cherry Point, NC	0	1		
Camp Pendleton, CA	1	4	3	3
Twentynine Palms, CA	0	2		
Yuma, AZ	1	1		
Air Force				
Andrews, MD	0	1		
Barksdale, LA	1	1	3	3
Edwards, CA[a]	0	2	3	2
Little Rock, AR	1	1		
Total	13	27	18	11

[a]Installations that had completed self-study but that had not yet become accredited at the time of our visit.

continental United States (CONUS). However, we supplemented these visits with a visit to two major commands (see below) in the Pacific to obtain information about MCCA implementation experiences in that region. We also visited two CONUS major commands so that we had a context for better understanding what we learned from the Pacific major commands. Within the continental United States, we attempted to obtain a geographically dispersed sample.

In all, the final study sample included 17 installations distributed evenly across the four services: four Air Force, five Army, four Navy, and four Marine Corps installations (see Table 2.3 for the installation list). The selected installations represent a mix of the categories dis-

cussed above. Two of the installations were classified as having had relatively easy experiences with the MCCA implementation process. Ten were rated as average, and five were represented as having had a difficult time meeting the requirements of the act. Ten of the installations had successfully accredited at least one CDC, and three of these had two accredited centers. Four centers in the sample had been accredited before the June 1, 1991, deadline. Seven were accredited between the summer of 1991 and the end of 1992; two received accreditation in 1993. Three nonaccredited centers had completed the self-study and had submitted all the materials to the National Academy of Early Childhood Programs (see below for details). One installation was waiting for a validation visit, one had not passed on the first attempt, and one had failed to be accredited after two validation visits. The number of centers and of accredited centers at the installations visited are shown in Table 2.3.

In addition to the installation visits, interviews were conducted at the DoD, and at four major commands: Pacific Air Force (PACAF), U.S. Army Pacific (USARPAC), Training and Doctrine Command (TRADOC), and the U.S. Military Academy (USMA).

CONCLUSIONS

Our three-pronged data analysis provides us with rich data about MCCA implementation from the top down and from the bottom up. Interviews with a range of individuals who had a hand in MCCA implementation on local installations combined with survey data from CDP managers worldwide and the analysis of documents in headquarters files allows us to examine the process from many perspectives.

At the same time, it is important to remember in reviewing our analyses and conclusions that each data source has its own limits. Interview data are biased in unmeasurable ways by the fact that interviewees were not selected at random. Small numbers of individuals in each role position make this limitation more significant. The survey data, while representing far more respondents, measure people's *perceptions* of facts, and not the facts themselves. In a few cases, these perceptions were not entirely consistent with "harder," contemporaneous data. And, of course, these perceptual data collected in 1993 may not correspond at all to the situation today. We have

footnoted these changes over time in policy, practice, and outcomes in many places in the report. Finally, the analysis of documents is based on a small number of documents selected for their face relevance drawn from service headquarters files that were maintained in different ways. In relying on the three data sources, we believe that we balance the problems and limitations of each, but do not eliminate them entirely.

We turn now to an examination of the implementation of the nine most important MCCA provisions, discussed in order of their appearance in the legislation. We begin with the appropriated funds match, one of the most contested and difficult MCCA provisions.

Chapter Three

APPROPRIATED FUNDS MATCH

Section 1502, Funding for Military Child Care for FY90, lays out the conditions for the provision of appropriated funds to CDCs and CDPs in that year, a policy that was subsequently adopted for future years as well. This provision has proven to be one of the most contested and difficult aspects of MCCA implementation. Section 1502 specified that:

> the amount of appropriated funds available during fiscal year 1990 for operating expenses for military child development centers shall not be less than the amount of child care fee receipts that are estimated to be received by the Department of Defense during that fiscal year.

In discussions with actors at all levels of the military, there was consensus that the key and most immediate problem posed by the passage of the MCCA was the lack of an appropriation attached to the legislation combined with a rapid, mid-year implementation mandate. As a result, finding money to fund the many MCCA provisions, particularly the appropriated funds (APF) match, was a major issue for everyone, and a source of considerable anger among those disposed to oppose the MCCA in the first place.

The document abstraction analyses reveal that funding was the most frequent topic coded in materials pulled from services headquarters files. Indeed, the Army is the only service in which funding was *not* the most frequently mentioned category. This is not surprising given the Army's long-standing and strong financial support for CDP. As one high-placed Army staffer told us, "Money was not the [MCCA

implementation] problem for us." The heavy focus on funding in non-Army services is equally unsurprising given MCCA implementation demands: short deadlines, mid-year start, and no appropriation. The funding issues that the services faced in the implementation of the MCCA are discussed below.

FINDING FUNDS

Many of the funding messages that we analyzed focused, naturally enough, on where the funds were to come from to support MCCA implementation in the early years before funds could be included in the POM. A Navy message (4036) dated January 25, 1990, is typical in laying out how much major claimants must provide, and in telling major claimants that these funds must be taken from other funded programs. The Army, in a message dated February 27, 1990, makes clear to Major Commands (MACOMs) that the costs of MCCA requirements must be borne for the most part by APF$, since fees cannot be raised enough under the new fee limits to cover much of these costs. Other messages repeat the obvious: There was not enough money in the first years of implementation because the mid-year start meant that FY90 funding did not include the resources necessary to meet Congressional intent.[1]

An undated Marine Corps Point Paper on USMC child care notes that "Congressional budget increases had to be funded out-of-hide." Digging into other funds created particular problems for the Marine Corps. An undated Marine Corps information paper reports that despite taking money out-of-hide, some operational costs remained unfunded.

However, only the Marine Corps described funding problems as likely to severely undermine MCCA implementation. An undated Marine Corps Information Paper on FY92/93 Operations and Maintenance Marine Corps (O&MMC) appropriations for child care noted the lack of earmarked funds and concluded that the Marine Corps cannot fully comply with MCCA requirements without increased appropriations. We did not encounter this message—that full imple-

[1]For example, an Air Force message dated June 13, 1990, makes this point.

mentation would not be possible—in abstracted documents from any of the other services.

CALCULATING AND MEETING THE MATCH

A key issue with regard to funding concerned the implementation of the match between parent fees and APF$, particularly what was to be included in calculating it. The legislation provided no guidance concerning how to calculate the match. The subsequent DoD guidance of January 31, 1990, provided more information concerning what counted toward APF support (e.g., not utilities), but these guidelines seemed to lack clarity to those at the bottom. Installation comptrollers in particular told us that guidance concerning legal and administrative issues in meeting the match was very limited.

According to DoD and service-level managers, the idea behind the match provision of the MCCA was to ensure that more money was available to CDP programs at the same time that child care remained affordable to parents. The MCCA specified that parent fee revenue was to be exclusively devoted to caregiver wages; other expenses (e.g., for administration, training, supplies, and caregiver wages not covered by fee receipts) would come from APF$.

The overall scheme involved the use of parent fee income to pay caregivers who were employed in nonappropriated funds positions, a civilian personnel category that also includes many employees in officers' clubs, on golf courses, and in other recreational facilities. Appropriated funds would go to caregivers who filled GS positions.[2] Since the MCCA also required that the number of GS caregiver positions be increased substantially, it was important that a large amount of APF$ rather than in-kind services be available to CDPs.

Few APF$ were budgeted for child care when the MCCA passed. Thus, each APF$ diverted to child care in that first year (and several subsequent years) had to come out of ongoing activities. COs and

[2]NAF positions may draw on funds generated from within the CDC (these are almost exclusively fee revenues) and funds generated from outside the CDC. This latter category includes military exchange dividends or dividends from civilian recreation and/or welfare funds. GS positions are supported with taxpayer funds appropriated by Congress.

comptrollers were therefore motivated to limit the amounts of APF$ flowing to CDPs. If they could apply the value of utilities and maintenance to the APF commitment, the amount of actual APF$ required to meet the match would be reduced. The fee schedule set up by the DoD assumed that the match *excluded* in-kind services such as utilities and maintenance. If these items were included in the APF$ match, then a subsidy from nonappropriated funds other than parent fees, usually golf course or other profits, would be necessary to fully fund costs. If in-kind support was excluded, more APF$ would be needed.

More than one service headquarters respondent told us that the lack of specificity on these matters from DoD was intentional, so that the individual service comptrollers could resolve these issues in ways that were most advantageous to them. But this discretion, which DoD interviewees told us was *not* intended, slowed and complicated implementation. Repeated queries concerning the elements of the match took a great deal of time and caused a great deal of trouble. Was it to include only direct day-to-day operating costs? Repair and maintenance? Moreover, the discretion was more apparent than real, according to several respondents. Even if the components of the match were not clearly specified, the DoD's fee schedule was based on the assumption that only direct costs would be included in the match. If other costs were included, there would almost certainly be a need for a NAF subsidy, something that no one liked.

Further complicating implementation of the match was a lack of clarity concerning whether the DoD and Congress intended to treat the matter as a target toward which the services and installations should work, or a floor, an absolute minimum funding level. The implications were enormous. A floor represented a minimum requirement, something that installations were expected to achieve, and to achieve fairly steadily and quickly. In considerable contrast, a target was a goal and, like all goals, might or might not be achieved, and certainly would not be achieved with dispatch. Documents abstracted from HQ files indicate that a good deal of time and energy was devoted to questioning whether the match represented a target or a floor.

The uncertainty at the service and installation level about how to define and meet the match was compounded by the DoD's own uncer-

tainty on these matters. An undated document entitled "Talking Paper on Report on Air Force Child Care Obligations," which was pulled from Air Force files, expresses the uncertainty very succinctly, noting that the match has been described by DoD at various times as *both* a target and a floor.

> DoD issued funding levels for each service based on parent fees expected to be generated in FY90.
>
> . . . OASD (FM&P) [Office of the Assistant Secretary of Defense, Force Management and Personnel] issued as floors, then DoD Comp issued memo saying floors were not statutory requirement.
>
> . . . But do express the intent of Congress.
>
> Based on initial guidance, USAF/FMA issued funding floors for commands.
>
> . . . Have since rescinded, based on DoD guidance; change to targets.
>
> . . . Commands and installations are now confused.

A number of documents abstracted from each service headquarters question the status of various MCCA provisions in hope of reducing the financial burden on services and installations. For example, in June 1990, the Air Force issued an information memorandum (3106) that provided funding guidance on child care. This memo reports that "since the recent OSD Comptroller ruling held that the floors were not statutory in nature . . . we have asked for a ruling on which, if any, of the remaining parts of the act were statutory requirements." The memo goes on to say, "HQ/USAF/JACM has provided an opinion which clearly indicates the remaining provisions of the act are required by law." It goes on to note, "clearly, it is the intent of Congress that the Air Force . . . reach the funding levels stated in the act." Just three months after the DoD issued its implementing guidance, the Air Force had determined that MCCA funding targets were to be treated as floors.

The Navy and Marine Corps dealt with this same issue of funding floors or targets rather differently. In a memo from counsel dated January 5, 1990, the writer notes that "the real problem to be addressed is how to manage the child care program within existing budgetary constraints to arrive at a sufficient level of funding so that the [child care] fees are realistic in terms of the families' income." The memo goes on to state that the funding levels in the MCCA "do not create statutory floors as drafted, but express the intent of Congress that at least those amounts should be applied to the programs." A message dated 3/10/90 reinforced this perspective, noting that considering the lack of any additional appropriation for child care and the timing of implementation in the fiscal year, "matching parent fees with APF is a target, not a requirement."

A Navy message dated 12/5/90 lists APF and end-strength targets by major claimant. It asks addressees to "compare above targets to budgeted amounts and evaluate internal realignments from other BOS areas if shortfalls exist." A message dated 3/29/90 asks addressees to document the effect of such realignments on other programs. It asks for "specific, hard-hitting impact," e.g., "will close fitness center two days a week, impacting 1,400 sailors;" "will preclude equipment procurement for summer sports program precluding 10 afloat and 6 ashore commanders participating in intramural competitions . . . ." Such directives suggest that the Navy and Marine Corps had chosen a path of some resistance to MCCA funding requirements. Yet, in the same message, it was noted that the Navy "is being held accountable by Congress and the Office of the Secretary of Defense" for expanding child development services in FY90. The mixed nature of the message, "demonstrate the pain, don't blame us, we have to comply" is the sort of inconsistent message that Goggin et al. (1990) believe complicates implementation.

Such inconsistencies were largely lacking in the abstracted Army documents. For example, while a message dated 2/27/90 notes that the costs of implementing MCCA requirements must be borne by APF$ since fees cannot be raised substantially, this is simply a statement of fact. No one is asked to document the pain. Early guidance on the MCCA (2/27/90) dealt with the issue of "specific funding floors." The Army made clear in this document that "this is a floor," and took the additional step of noting that these floors are "not a ceiling."

Column 1 of Table 3.1 summarizes key differences across services in funding policies with regard to floors and targets. As column 1 shows, cross-services differences in interpretation are substantial. The Marine Corps interpreted the match as a target rather than a requirement. The Navy laid out targets by major claimant, but its messages concerning targets and floors were mixed and inconsistent. In some contrast, the Air Force unequivocably defined targets as floors, the same position that the Army took. But the Army went one step further by indicating that the floors described in the legislation do not represent all resources necessary to meet the MCCA's legislative intent. (See below for discussion of additional Table 3.1 data.)

We asked respondents to our survey to indicate what was included in the calculation of the required APF$ match at the time of our survey. We provided five response categories: wages, supplies and equipment, utilities, maintenance, and other.

Table 3.1

Services' Status on Key Funding Components

Service	Funding Policies (Floors and Targets)	Per Capita CDP Expenditures (FY94) ($)	Execution Rates of APF$ Directed by the MCCA as of 3/31/90 (%)
Air Force	Targets = floors	123.58	9
Army	Targets = floors, not a ceiling. Does not represent all resources necessary to meet legislative provision or intent	159.62	49
Marine Corps	APF fee match is target, not requirement	76.75	13
Navy	Laid out targets by major claimant. Mixed and inconsistent messages	95.84	38[a]

SOURCE: Undated chart found in Air Force headquarters files.

[a]Best estimate of execution.

We found, not surprisingly, that wages were almost universally included in the match (91 percent of respondents indicated that wages were included), and that supplies and equipment were a close second, with 85 percent of respondents indicating that they were included in calculating the match. Utilities and maintenance were far less likely to be included, which reflects confusion in the field about DoD guidance. Thirty-nine percent of respondents indicated that utilities were included, and 40 percent included maintenance. As shown in Table 3.2, there were some differences across the services in the pattern of items included in the match. Army respondents only rarely included utilities, maintenance, or other items in the match, whereas the other services were likely to do so. More than 50 percent of Navy respondents indicated that they included utilities and maintenance in the match; the figures were slightly lower for the Marine Corps and the Air Force. An analysis of patterns (not shown) reveals that the most common formula for the match reported by Army respondents was one that includes only wages and supplies and equipment. This was also the most common pattern in the Marine Corps and Air Force. However, in the Navy, the most common pattern was one that includes wages, supplies and equipment, utilities, and maintenance. These different approaches to funding reflect substantial differences in the level of financial commitment to CDP before the MCCA, and differences in culture and capacity that are reflected in these pre-MCCA funding commitments.

Table 3.2

Items Included in the Calculation of the APF$ Match

Service	Wages	Supplies and Equipment	Utilities	Maintenance	Other
Air Force	88[a]	82	40	42	27
Army	100	86	12	18	14
Marine Corps	83	100	42	50	17
Navy	88	86	58	55	22
Mean	91	85	39	40	22

SOURCE: Data from mail survey.

[a]Cell entry is the mean percentage of survey respondents in designated service who indicated that the item in that row was included in calculating the match at the time of the survey.

What may be the most interesting finding with regard to these data is the variation in responses *within* services. This variation may reflect an intentional lack of specific guidance that allows installation-level actors to develop the most advantageous formulas for their situation. It may also reflect a lack of uncertainty by installation-level personnel concerning what was expected of them. This latter possibility is reflected in the materials that we abstracted from headquarters and in our field notes, as discussed below.

PRE-MCCA FUNDING FOR CHILD CARE

The data available in the abstracted documents reveal that the services' rankings both in terms of total spending for CDP and in terms of per capita distribution of CDP expenditures have been relatively constant over the FY89 to FY94 period. The Army's place at the top and the Marine Corp's at the bottom has not changed at all.[3] Air Force and Navy spending levels have resulted in switches in ranks two and three over the period FY93 to FY94, according to an Information Paper (1033) dated 6/93 found in Marine Corps headquarters files,[4] but there has been no change in rank over that two-year period if one looks at per capita distribution, as shown below. Because service size is variable, per capita spending, shown in column 2 of Table 3.1, is an arguably more meaningful measure.

Similar differences by service were apparent early on as well. An undated document abstracted from Air Force files titled "Execution of APF's and Positions Directed by the MCCA of 1989" indicates that as of 3/31/90, at the very beginning of the MCCA implementation process, service rank orderings based on percentage of APF$ authorized that had been executed found the Army at the top and the Air Force at the bottom (see column 3 of Table 3.1).

Most of the people to whom we spoke in the field told us that the funding difficulties imposed by MCCA requirements were exacerbated by contextual problems. In particular, many installations were

[3]Since an infusion of DoD funds to Marine Corps CDP in fall 1992, the Marine Corps has achieved and maintained a much higher funding level per space than in the past.

[4]Implementing guidance had come from DoD on 3/23/90, but no service had yet produced its own implementing guidance by that date.

beginning to experience funding cutbacks by the time of initial MCCA implementation; interviewees on Navy and Marine Corps bases in particular indicated that the funding of new positions in CDCs while positions in arguably more mission-central positions were being cut created a lot of bad feeling toward the MCCA. These negative feelings were not assuaged when child development was specifically exempted from the first DoD hiring freeze.

Several interviewees told us that the creation of new positions in CDCs in the face of stable or declining positions on the base forced COs to reduce staff engaged in activities at boat docks, supply depots, and other base activities. Said one CO, "child care is money coming out of defense for babysitting." Several comptrollers noted that this pattern meant that each year, child development was getting a larger share of appropriated funds positions. One comptroller noted that because of the MCCA requirements and the zero-sum funding situation, child care was getting an increasing proportion of resources during a time of downsizing. At the same time, even the more recalcitrant command-level interviewees indicated that the fact of the MCCA mandate meant that they had little choice but to comply.

LEVEL AND TIMING OF APF FUNDING

Our fieldwork interviews reveal substantial differences across services in the level of APF$ that was provided to installations from headquarters or major command levels, and in the speed with which these funds reached installations. Although all installations were on their own at the very beginning, the Army was able to get more money to installations sooner than the other services. This no doubt explains why Army respondents were less likely to include things other than wages and supplies and equipment in the match: They did not have to by the time of our survey because they could make the match (and then some, see below) without much difficulty.

In considerable contrast, Marine Corps interviewees reported that adequate APF funds were slow in arriving. Interviewees at one Marine base that we visited told us that they did not get adequate funding for the MCCA until FY93. The reasons for the delays are varied. In the case of the Marine Corps, funds were simply not available. The situation was less clear in the Navy. In at least one case, the

major claimant had funds on hand but failed to get them out to the bases until one CO petitioned headquarters.

The difficulties that Marine Corps employees and personnel in other services experienced in getting APF$ are reflected in the responses to our mail survey, which indicated that about a third of respondents told us that their installation did not meet the required APF match (see Table 3.3) at the time of the survey (mid-1993).[5] The table also reveals significant differences across the services in the percentage of respondents who reported that their installation had not met the required APF match. Army respondents were most likely to report having met the match, followed by the Air Force. Marine Corps and Navy respondents report lower percentages of installations meeting the match.

Even among those respondents who had met the match, there was a considerable percentage who had done so only a short time before the survey. As Table 3.4 shows, almost half of the respondents had first met the match after FY91.

Table 3.3

Percentage of Respondents Meeting the Match, by Service

Service	Mean Percentage	Standard Deviation	Frequency
Air Force	71	46	86
Army	77	42	62
Marine Corps	62	51	13
Navy	51	50	67
Mean	66[a]	47	228

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.01$ (F-test).

[5]These data contradict DoD data from the same time period, which indicate that across services, the match was achieved in 1992. A possible reason for the discrepancy is that the CDP personnel completing our survey may not have included GS positions (which are funded with APF$) in the match because they do not control that budget. In fact, if an installation had filled GS positions, they had met the match. (See Table 8.8 for the numbers of new GS positions and NAF conversions.) Alternatively, DoD data reflect the point at which the match was met at an *aggregate* level, whereas our data are installation-specific.

Table 3.4

Fiscal Year Match First Met

Fiscal Year First Achieved Match	Frequency	Percentage	Cumulative Percentage
FY89	1	0.71	0.71
FY90	23	16.43	17.14
FY91	48	34.29	51.43
FY92	51	36.43	87.86
FY93	17	12.14	100.00
Total	140[a]	100.00	

SOURCE: Data from mail survey.

[a]77 respondents had not met the match; 28 did not respond to the question.

On average, it took those respondents who had met the match by the time of our survey two years and five months after the passage of the MCCA to do so. Not surprisingly, there were significant differences across the services in the average length of time it took to meet the match.[6] As indicated in Table 3.5, the Marine Corps respondents reported being almost a full year later in achieving the match than Army respondents.

Table 3.5

Average Time to Meet the Match

Service	Date	Frequency
Air Force	May 1991	60
Army	March 1991	40
Marine Corps	February 1992	5
Navy	July 1991	35
Mean	May 1991[a]	140

SOURCE: Data from mail survey.

[a]Dates are significantly different: $p < 0.06$ (F-test).

[6]To run a test of statistical significance, dates were converted into months since MCCA passage.

Over time, funding problems have lessened. Several factors account for improvements in this area. First, the simple passage of time has allowed the budget process to catch up with MCCA implementation. POMs in the succeeding years were programmed to ensure that funds for MCCA implementation would be available. Second, effective lobbying by the DoD has resulted in substantial amounts of new funds going to child development in the services. Thus, conversions of NAF caregiver jobs to GS positions (a time-consuming process that we discuss in more detail in Chapter Eight) helped to meet the match over time.

Survey respondents were asked to indicate whether or not the amount of appropriated funds that they had available in each year from FY90 through FY93 was adequate to meet MCCA requirements. As expected, we found that in the first, partial year of MCCA implementation, 69 percent described the amount of APF$ as inadequate. Each year thereafter, the percentage that described the amount of funds as inadequate declined substantially. In FY91, 57 percent described APF$ as inadequate. By FY92, this figure was 38 percent. It declined to 33 percent in FY93. Nevertheless, it is striking that by FY93, when there had been sufficient time to program funds for MCCA implementation into the POM, one-third of responding child care managers described the amount of APF$ available as insufficient. (See discussion below of reasons why APF$ may be perceived to be insufficient.)

As expected, there were substantial differences in the proportion of respondents who described APF$ as adequate in each year across services. As shown in Table 3.6, in FY90 and FY91, a higher percentage of Army respondents described APF$ as sufficient than respondents from the other services. The means across services were significantly different at less than the 0.05 level of significance in both years. What is striking in Table 3.6 as one compares data from FY90 with those from FY91 is that the percentage of Army respondents indicating adequate APF$ increased substantially from FY90 to FY91, from 44 to 59 percent. The Air Force percentage also increased substantially, from 32 to 46 percent, over that same time period. The Navy percentage increased only from 21 to 30 percent during this period; the Marine Corps level of adequacy did not increase at all.

Table 3.6

Percentage Reporting Adequate APF$ to Meet MCCA Requirements, by Service and Fiscal Year

Service	FY90	FY91	FY92	FY93
Air Force	32	46	74	78
Army	44	59	68	67
Marine Corps	9	9	18	50
Navy	21	30	47	54
Mean	31	43	62	66

SOURCE: Data from mail survey.

By FY92, our retrospective data reveal important changes in the funding landscape. By this time, more Air Force than Army respondents remembered the amount of APF$ that they were receiving as adequate, as shown in Table 3.6. Seventy-four percent of Air Force respondents indicated that in FY92, they had adequate APF$, whereas the comparable figure for Army respondents was 68 percent. In describing that same year, 47 percent of Navy respondents indicated that they had had adequate APF$ support. The Marine Corps figures were the lowest but had doubled—to 18 percent indicating adequate APF$ support—from FY91. These cross-service differences were significantly different at the 0.000 level of significance.

By FY93, something approaching perceived parity had been achieved across the services. As shown in Table 3.6, 78 percent of Air Force respondents and two-thirds of Army ones indicated that they had had adequate APF$ in that year. Comparable figures for the Navy and Marine Corps were 54 and 50 percent, respectively. Particularly with regard to the Marine Corps, this represented an enormous increase and an indication that a difficult effort to provide APF$ support to child development was moving forward. Nevertheless, the means differed significantly at the 0.02 level.

Not surprisingly, the perceived adequacy of APF$ was related to the reported difficulty in implementing MCCA program changes. Those who indicated that the amount of APF$ was adequate for three or four years reported significantly less difficulty in implementing required program changes (not shown).

The two-thirds adequacy level in FY93 shown in Table 3.6 when POM programming had made it to the field deserves note. Part of the reason for perceived adequacy not being higher may be due to a problem identified by numerous fieldwork interviewees: a fee schedule set so that even when fees were fully matched there would be insufficient money to cover MCCA implementation. (See Chapter Five for more detail on this point.) However, this was not the inevitable scenario. One installation that we visited had a fair representation of higher-ranking members using the CDC. In fact, there were enough high-ranking members using the CDC in this high-cost area that the CDC was making a profit.

Other mail survey data indicate that at least some CDCs were receiving APF$ that exceeded the required match; APF$ were likely to have been seen as adequate in these instances. As shown in Table 3.7, almost three-quarters of respondents indicated that they currently received APF$ beyond the match.

Our interview notes reveal that most of the 17 installations that we visited were providing a NAF subsidy to child development at the time of our visit to cover the shortfall created by insufficient income from combined parent fees and APF$. One installation provided additional funds for CDCs from air show income. Four installations reported that they did not need to subsidize CDCs with NAF funds because their CDCs were making a profit. For some, this subsidy was galling. A child development coordinator on one Marine Corps base

Table 3.7

Percentage Receiving APF$ Beyond the Match, by Service

Service	Percentage Exceeding Match	No.
Air Force	65	71
Army	88	51
Marine Corps	83	6
Navy	65	43
Mean	73[a]	171

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.02$ (F-test).

told us that her CO had told her, "If you can't make it on a 50 percent match [of appropriated funds to fees], then you close them [the CDCs] down."

Data from the mail survey confirm widespread NAF subsidization. As shown in Table 3.8, more than two-thirds of respondents reported that they had received NAF (excluding parent fees) in the last fiscal year (FY92).[7]

Table 3.8

Percentage Receiving NAF$ in FY92, by Service

Service	Percentage Receiving NAF$	No.
Air Force	68	85
Army	78	65
Marine Corps	62	13
Navy	61	67
Mean	69[a]	230

SOURCE: Data from mail survey.

[a]Means are not significantly different (F-test).

CONCLUSIONS

The appropriated funds match was a complex provision of the MCCA. Achieving it depended upon the funneling of APF$ out of other activities and into CDPs, clear guidance concerning what should be included in the match, unequivocal messages concerning service and DoD expectations, and the hiring of GS employees.

All of these elements were difficult even for committed implementors; many were not committed. The complexity of these components provided services, major commands, and COs who did not

[7]NAF subsidy levels have declined in recent years, in response to pressures to reduce them. The provision of fiscal management training by at least one major command and increased accountability in the APF$ system have also served to reduce dependence on nonfee NAF. The Army, in particular, has shrunk an enormous NAF subsidy to near zero.

support the MCCA with enough uncertainty to substantially delay implementation.

The fact that the match required that APF$ be forthcoming delayed its implementation as well. Limited resources, lack of time for budget modification, and resistance in some cases slowed the process considerably.

Our survey data suggest that problematic as it was to meet the match, implementation was achieved just a few years after MCCA passage. The influx of APF$ facilitated the implementation of many other MCCA provisions, as Congress intended. We examine these below.

Chapter Four

CAREGIVER PAY PROGRAM

Once hearings began on a military child care act, one of the first issues to emerge was the high rate of staff turnover in child development centers. It became clear in the course of the hearings that the low salaries that caregivers earned were a major factor in their decisions to leave caregiver jobs.

A key provision of the MCCA responded to these concerns by raising caregiver salaries. Section 1503 explicitly linked higher salaries to the goal of a more stable and higher quality workforce,

> For the purpose of improving the capability of the Department of Defense to provide military child development centers with a qualified and stable civilian workforce, the Secretary of Defense shall conduct a program as provided in this subsection to increase the compensation of child care employees .... The program shall apply to all child care employees who are directly involved in providing child care; and who are paid from nonappropriated funds. Under the program, child care employees . . . shall be paid . . . at rates of pay substantially equivalent to the rates of pay paid to other employees . . . with similar training, seniority, and experience.

To increase the likelihood that higher pay would ensure a higher quality as well as a more stable workforce, salary increases were to be tied to the completion of training milestones. The Caregiver Wage Plan required the completion of the 13 Military Child Development Employee Training Modules or a DoD-approved equivalent. Headquarters respondents told us that this link of caregiver wage increases to training was made as well to increase the political palatability of increased wages. "If Congressmen and Senators asked, 'why

should I pay people more who seem to be perfectly willing to work for their current salary?' the training link would allow MCCA supporters to tell them, 'you get better trained staff,'" said one respondent.

The MCCA specified that caregiver wages were to increase within six months. And indeed, caregiver wage increases were one of the most rapidly achieved MCCA requirements. Air Force personnel told us that pay increases were implemented by June 1990. Army personnel told the same story: Pay increases went into effect in an "unprecedentedly" short time.[1]

Respondents to the mail survey were asked to provide the average starting salary of CDC caregivers before the MCCA. As shown in Table 4.1, wages were very low before the MCCA's passage.

Wage rates across services are significantly different. The Army and Navy were paying the most before the MCCA, and the Marine Corps was paying the least. Part of the reason for the Navy's number one rank in salaries, according to numerous fieldwork interviewees, is that Naval bases tend to be located in high-cost areas. In such

Table 4.1

CDC Caregiver Average Hourly Starting Salaries Pre-MCCA, by Service

Service	Starting Salary ($)
Air Force	4.50
Army	4.74
Marine Corps	4.35
Navy	4.89
Mean	4.67[a]

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.002$ (F-test).

[1]Rapid implementation was possible because of the work of a DoD task force on caregiver wages, which had begun to examine wages and develop recommendations for a wage plan in early 1989, before the passage of the MCCA. Some of the early response reflected the implementation of a NAF caregiver wage test, which was a component of the MCCA described in more detail below.

locations, potential caregivers can command a higher salary. In contrast, Marine Corps bases tend to be located in lower-cost places, such as the South.

Our field data reveal that in many locations, these pre-MCCA starting salaries were below the wages being offered at the same time at other locations on the installation. Often, caregivers to whom we spoke mentioned Burger King in this context. Not only were Burger King salaries higher, they said, but working conditions were better: A number of respondents mentioned, for example, that split shifts were common in CDCs and that the work, particularly changing diapers, was less pleasant. Other respondents noted that there were few, if any, nonmonetary advantages of CDC caregiver jobs that might compensate for low salaries.

Respondents everywhere agreed that there were no efforts made to present caregiving as a career track; consequently, caregivers did not perceive it that way. There was no reason for most of them to choose a CDC position over one at Burger King unless they simply liked little children, which many of them in fact did. But when a job opened up at Burger King, the appeal of little children was not always enough to hold them. Nor were there any mechanisms or efforts to present caregiving as a profession to be proud of. Given the low wages and the absence of such nonmonetary benefits to low-pay caregiving jobs, the rate of turnover was very high. CDCs could not successfully compete for the best employees and were sometimes forced to retain poorly performing personnel.

The NAF caregiver pay program had an enormous effect on entry-level salaries for caregivers. This test, begun in June 1990, ran for two years. Under the test, two NAF pay bands were established that would provide interim pay increases at critical times to encourage retention and reward increased competency. Entry-level pay was equivalent to a GS-2, and full performance level (with training completed) equivalent to a GS-4. When training was completed, caregivers had to be given wage increases.

The test was successful in reducing turnover from annual levels reported to be as high as 200 percent to below 50 percent in each ser-

vice. (DoD Information Paper provided at 1992 Commanders' Conference, n.d.)[2]

By comparing hourly wages reported by our survey respondents in Tables 4.1 and 4.2, it is apparent that the wages for entry-level staff increased by almost $2 per hour from pre-MCCA levels to levels at the time of our survey in 1993. This difference is highly statistically significant (paired t-test).

Of equal importance, mean differences in wage levels across services are no longer significantly different from each other, as they were before the MCCA (see Table 4.1). This indicates that an important MCCA goal—standardization of salaries across services—has been achieved by the caregiver pay program.

There is evidence that the linkage between wage increases and completion of training milestones was important as well. Fieldwork interviewees told us that training requirements tied to salary increases had two different salutary effects. Most important, the linkage provided caregivers with a strong monetary incentive to complete training modules and demonstrate competence. Indeed, several field-

Table 4.2

Average Current Entry-Level Hourly Wage, by Service

Service	Entry-Level Hourly Wage ($)
Air Force	6.47
Army	6.53
Marine Corps	6.60
Navy	6.52
Mean	6.51[a]

SOURCE: Data from mail survey.

[a]Means are not significantly different (F-test).

[2]Given that many caregivers are spouses of military members, moderate turnover must be expected and will occur despite system changes. CDC directors did tell us that most caregiver resignations now occur because a military member has been transferred.

work interviewees told us that the importance of this monetary incentive was clearly demonstrated by its absence in youth programs. On several of the installations that we visited, youth staff, inspired by the new child development training requirements, attempted to institute similar training requirements for their staff. But without the wherewithal to link training with salary increases, these efforts were uniformly unsuccessful.

Second, in some instances, training requirements served to weed out less motivated caregivers. Several interviewees told us that soon after the training requirements went into effect, a small number of caregivers in their CDCs tendered their resignations, saying that the new requirements were too burdensome. At the time of our fieldwork, there seemed to be another group on the verge of departure: those who had reached the deadline for completion of training who had not completed the training requirements. On one installation that we visited in March 1993, this milestone was just weeks away. The CDC director told us that she was preparing to terminate 10 percent of her caregiving staff for failing to complete required training by the deadline.

There was a tendency for those who had left or would be leaving because they objected to or failed to complete required training to be older, less well-educated caregivers, according to CDP and CDC directors to whom we spoke. A few interviewees at all levels of the system rued the departure of these "grandmotherly" types. But the majority view was that overall, the system benefited from their departure, leaving openings for better-educated, more career-oriented caregivers.

Respondents to our mail survey generally supported the idea that the new system of higher wages tied to increased training improved the quality of applicants for caregiver positions. As shown in Table 4.3, respondents in all services generally agreed that the new system resulted in improvements in the education or experience level of caregiver applicants. Again, the lack of cross-service differences is positive, suggesting that the new system is perceived to be functioning equally effectively in each service.

Survey respondents were also asked whether wage increases had increased the number of applicants for caregiver positions. The overall

Table 4.3

Perceived Improvement in Applicant Education or Experience Levels Post-MCCA, by Service

Service	Mean Improvement Level	No.
Air Force	1.2	86
Army	1.1	62
Marine Corps	1.5	13
Navy	1.1	70
Mean	1.2[a]	231

SOURCE: Data from mail survey.

[a]Improvement was assessed on a scale from –1 to 2, with –1 = some decline in quality, and 2 = big improvement in quality. Thus, the overall mean of 1.2 indicates that respondents generally saw improvement in quality under the new system. Means across services are not significantly different (F-test).

mean indicates some increase in numbers of applicants across services. As shown in Table 4.4, means were significant across services, with Air Force and Army respondents reporting the largest increases, and Navy respondents the smallest ones.

Thus, survey data seem to indicate that the caregiver pay program has been successful in achieving its ultimate goals: a better-trained, more stable caregiver workforce. There was widespread agreement among fieldwork interviewees that turnover had decreased dramatically since wages had increased. Survey data support these perceptions. As shown in Table 4.5, reported annual turnover rates among CDC caregivers before the MCCA averaged almost 48 percent across services. Differences across the services were not significant.

Turnover rates declined by more than 50 percent as reported by our survey respondents. As shown in Table 4.6, overall caregiver turnover rate across services at the time of the survey was 23.6 percent. The difference between pre-MCCA and post-MCCA turnover rates is highly statistically significant.

Table 4.4

Perceived Increase in Number of Applicants Post-MCCA, by Service

Service	Mean Increase in No. of Applicants	No.
Air Force	1.5	86
Army	1.3	61
Marine Corps	1.2	13
Navy	1.1	69
Mean	1.3[a]	229

SOURCE: Data from mail survey.

[a]Increases were assessed on a scale from 2 to –1, with 2 = big increase, and –1 = some decrease. Thus, the overall mean of 1.3 indicates that respondents generally reported some increase in the number of applicants under the new system. Means across services are significantly different: $p < 0.03$ (F-test).

Table 4.5

Reported Annual Pre-MCCA Caregiver Turnover Rates, by Service

Service	Reported Turnover Rate (%)	No.
Air Force	51.1	60
Army	43.7	49
Marine Corps	50.5	10
Navy	47.1	53
Mean	47.7[a]	172

SOURCE: Data from mail survey.

[a]Means are not significantly different (t-test).

Table 4.6

Annual Current (Post-MCCA) Caregiver Turnover Rates, by Service

Service	Reported Turnover Rate (%)	No.
Air Force	22.5	78
Army	22.6	66
Marine Corps	32.1	13
Navy	24.1	67
Mean	23.6[a]	172

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.0000$ (t-test).

Looking at differences pre-post across services, we find that the differences are not significantly different by service. As shown in Table 4.7, declines in turnover rate are similar across services.

Data from our fieldwork visits support the notion of increased professionalization under the new wage and training structure. For example, one MACOM CDP specialist told us that caregivers were staying longer because of both higher wages and feelings that they were involved in a *profession* and were on a career ladder. A sense of career progression was evident to several T&C specs to whom we

Table 4.7

Differences in Caregiver Turnover Rates from Pre-MCCA to Current Time, by Service

Service	Reported Turnover Rate (%)	No.
Air Force	–27.78	59
Army	–25.49	49
Marine Corps	–20.30	10
Navy	–25.87	53
Mean	–26.09[a]	171

SOURCE: Data from mail survey.

[a]Means are not significantly different (t-test).

spoke. They reported that high percentages (in one location, over half) of caregivers had completed Child Development Associate (CDA) credentials and some had even gone on to get baccalaureate degrees.

CONCLUSIONS

The findings from our field visits and survey data suggest that the caregiver pay program has been extremely effective in achieving its goals. Caregiver wages increased substantially. Caregiver turnover declined by more than half. Because wage increases were tied in the legislation to completion of training milestones, it is reasonable to conclude that caregivers are also far better trained than they were before the MCCA.

Higher wages and training also appear to have instilled a sense of professionalism in many caregivers. There is some evidence that caregivers are parlaying the required training into CDA credentials, and some are even pursuing B.A. degrees.[3]

As standardization across CDCs increases, a major barrier to a professional career as a caregiver may decline. More standardized training and acceptance of the CDA will enable caregivers to enter a new CDC at a higher level and obviate the need to repeat completed training.

As discussed in a later chapter, the requirement that there be a T&C spec in each CDC facilitated these salutary outcomes. T&C specs have taken on CDA training in many locations, and have devoted considerable energy everywhere to improving the quality of training materials and the training process.

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[3]See Chapter Seven for further discussion of the CDA credential.

Chapter Five

PARENT FEES

Parent fees took on considerable significance in the implementation of the MCCA for two reasons. First, the manner in which fees were calculated changed substantially. The switch to a uniform fee structure based on total family income rather than on the pay grade of the military member(s) meant that military members who held part-time jobs in addition to their military duties and whose spouses worked for pay found that their fees increased dramatically, as much as twofold. We were told by some fieldwork interviewees that some of these parents left CDCs as a consequence, which affected the composition of some CDCs.[1]

Second, income from parent fees became the basis for calculating the amount of APF$ that had to be contributed to the operation of the CDC. Consequently, incentives to raise fee income became decidedly mixed. Although higher fees seemed desirable as the costs of care increased under MCCA provisions, each dollar of fee income had to be matched with APF$. In other words, each child enrolled in a CDC increased APF$ cost, and each extra dollar that parents paid in fees cost more as well. Especially in the first years of implementation, when there was no appropriation and no programmed funds in the POM, incurring additional obligations seemed unwise to many COs. So, the MCCA goal of increased availability clashed with the reality that higher fee income—coming from more

[1]Annual fee reports to the DoD do not indicate a substantial dropoff in the percentage of families in the highest fee categories.

children and higher fees per child—made life harder for those who had to come up with APF matching funds.

This chapter discusses the calculation of parent fees and the implementation of the new parent fee policy. It ends with a brief discussion of the short-term effects of the new policy on families and on CDCs.

CALCULATION OF PARENT FEES

The MCCA specified in Section 1504 that the Secretary of Defense:

> shall prescribe regulations establishing fees to be charged parents for the attendance of children at military child development centers. Those regulations shall be uniform for the military departments and shall require that, in the case of children who attend centers on a regular basis, the fees shall be based on family income.[2]

This component of the MCCA was designed to address concerns about affordability of care for lower-ranked personnel and about uniformity of costs across installations and services. It was for the former reason that the resulting regulations based fees on *total* family income; it was believed that such a stipulation more fairly addressed the issue of affordability. By specifying total family income as the basis for fees, military rank was not the sole determinant. Families in which the spouse worked outside the home for pay, and/or the military member had a part-time job and could therefore afford to pay more for care, would be expected to do so.

The Assistant Secretary of Defense, Force Management and Personnel (ASD (FM&P)), was charged with the development and annual publication of a schedule of fee ranges and maxima by income group that was to guide the establishment of CDC fees. The guiding policy in the establishment of these tables was that fees in CDCs were to remain at roughly their current levels. The 1990 fee table (see Table 5.1) established four income categories, each of which included a fee range within which installations could set fees.

[2]Subsequent regulations conditioned fees on *total* family income.

Table 5.1

Fee Policy, 1 September 1990 to 31 August 1991

Total Annual Family Income ($)	Range of Weekly Fees Authorized ($)
0–27,000	31–41
27,001–42,000	42–52
42,001–59,000	53–63
59,001 +	64–74

The ultimate aim of the new fee schedule was to provide affordable care and, with the required APF$ match, to cover the costs of care without the need for NAF subsidy. DoD analyses of the 1990 fee policy revealed that the fee policy had met the requirement to keep fees at their previous levels, but that an additional income category with higher fees had to be added to increase the spread in the middle fee categories. This additional category was added in 1991 and has continued since. In addition, an optional high-cost range was added (Table 5.2).

However, using the tables to set fees at a level that guaranteed half of CDC operating costs required thought, skill, luck, and the conversion of some fraction of CDC caregivers to GS positions. In the early years, the importance of these conversions was not well understood. Comments like that in the 1991 Commanders White Paper on the Military Child Care Act, which asserted that it was not possible in many instances to generate enough funds through fee income and APF$, reflected a lack of awareness of the critical role of GS positions in achieving fiscal balance.

Table 5.2

Fee Policy, 1 September 1991 to 31 August 1992

Fee Category	Total Family Income ($)	Range of Weekly Fees Authorized per Child ($)	Optional High-Cost Range ($)
I	0–11,000	31–39	34–43
II	11,001–27,000	35–45	38–48
III	27,001–40,000	46–57	49–61
IV	40,001–55,000	58–69	62–74
V	55,001 +	70–81	75–86

These fee tables caused many problems for some of our fieldwork interviewees, especially those who were less than enthralled by child care in the first place. One Colonel told us, for example, that Congress had capped child care fees until they were "ridiculous." The centers are "charging so little," he went on, "it's unrealistic."

An undated DoD Information Paper distributed at the 1992 Commanders' Conference noted,

> There are four factors that affect the Commanders ability to achieve the funding goals with the fee scales. They are:
>
> 1) Where in the ranges the fees are set. (Fees must be at the high end to generate adequate funds.)
> 2) The number of lower-ranking personnel using the center.
> 3) The number of spaces used for infants and toddlers. (This must be less than 40 percent of the spaces.)
> 4) The ability/willingness to fill GS slots, especially caregivers. (In general, one in six caregivers need to be GS.)

However, the DoD Guidance above was not available at the outset. COs did not know that fees had to be at the high end, or that infants and toddlers had to use less than 40 percent of spaces. Moreover, COs were not able to control the distribution of ranks among parent users of the CDC. This latter was perceived to be a major problem in the Navy, as discussed below.

Fieldwork interviewees on Naval installations were particularly likely to mention the problem of fees that were too low. The frequent location of Naval installations in high-cost coastal areas, combined with staffing on installations skewed toward the relatively low-ranked, they asserted, left many CDCs with rela- tively small fee revenues, and an APF$ match that was therefore not adequate to meet costs.

Other respondents in coastal areas objected to too-low fees for other reasons. Said one Marine Corps respondent, "Congress, in its stupidity, capped fees without regard for living costs that vary enormously in different areas. In southern California," this re-

spondent continued, "the fee structure means that Marines pay about half of what they would pay on the economy."

New fees also caused problems among higher-ranked personnel who, some fieldwork interviewees alleged, left in droves for care in the civilian sector, which was now cheaper for them than care in CDCs.[3] One fieldwork interviewee rued this pattern. She noted that, with the departure of many higher-ranked families, the CDCs became far more income-homogeneous places, which made them less interesting and valuable to children. However, some respondents told us that at least some of those who fled returned to CDCs when they realized that the quality of care was much better there. Aside from any social costs of such homogeneity, the remaining concentration of lower-ranked families meant that fees would *not* cover half of expenses, explained a Morale, Welfare, and Recreation (MWR) director to whom we spoke.

On another base, the fact that fees are not linked to age, as they are in the civilian sector, led to problems filling CDC preschool classrooms: in town, high earners could get cheaper (although lower-quality) care for preschoolers, because fees in civilian centers decline with the child's age in proportion to the increase in the child-to-caregiver ratio. This too created problems in the CDC, because the departure of older children tipped the balance toward more costly infants and toddlers in the CDC population. This meant that fee revenues could not cover half of costs.

Resistance to the new fee policy was reported to be high among those parents whose fees increased. A policy that required parents to bring in last year's income tax return to serve as the basis for the determination of total family income was argued by some to be an invasion of privacy. Others felt it was very unfair; they argued that a spouse's employment or a member's part-time job should not count against them in fee-setting. A decision that allowed families to withhold their tax return in exchange for accepting designation into the highest fee category effectively quelled the majority of the most vocal complaints.

[3]We were unable to find any documentation to support this allegation.

PARENT FEE IMPLEMENTATION

Despite animosity to the new fee policy and to some of its effects, the implementation of the policy itself was relatively smooth. Survey data indicate that the policy was implemented fairly quickly across installations and services. As shown in Table 5.3, the new policy was in effect in three services by the beginning of 1991. This implementation performance seems even better when viewed in terms of how fees normally are set in CDCs. In nearly all, fees run on a school-year calendar, so that changes, if any, are made at the beginning of the new school year, in September. Passage of the MCCA in November 1989 meant that the earliest possible time that the new policy could go into effect in most places was September 1990. Implementation by January 1991 would be not too far off the absolute soonest time that the policy could have been implemented in the vast majority of CDCs that worked off a school calendar.

Differences across services in implementation of the new fee policy were not significantly different at the 0.05 level, suggesting that issues of capacity may have been less significant in the implementation of this MCCA component than in others. The abstraction analyses support this notion. The vast majority of the documents concerning funding of MCCA focused on the *military's* share of CDC support, in the form of the APF$ match, not the parents' share, as discussed above. This is because, although implementation of the new fee policy required the DoD and the services to develop fee tables, which included income categories, fee minima and maxima,

Table 5.3

Average Date of Implementation of the New Fee Policy, by Service

Service	Mean	No.
Air Force	12/90	80
Army	3/91	50
Marine Corps	1/91	13
Navy	1/91	58
Mean	1/91	201

SOURCE: Data from mail survey.

and exemption and appeal policies, it did *not* require any funding on the part of the military, at least directly.[4]

At the same time, projected fee income was to be the basis for APF$ matching requirements; indeed, some command respondents argued that fees should be held down to keep the match as low as possible.[5] Others argued to keep fees low to help families cover child care expenses.

EFFECTS OF THE PARENT FEE POLICY

Fees Paid[6]

Survey data indicate that the new fee policy succeeded in three respects: First, the lowest-income families pay a fairly small fee. Second, the highest-income families pay considerably more; as shown in Table 5.4, the average weekly fee for those in fee category 5 is twice as much as the fee for those families in fee category 1. Third, there is considerable uniformity across services in weekly fees charged. As shown in Table 5.5, average weekly fees across services are almost the same. Differences across services in average fees are not significantly different.

Analysis of the percentage of parents in each fee category by service reveals that, with one exception (fee category 2), there are no differences by service in the distribution across fee categories (not shown). These findings are particularly interesting, since they seem to counter perceptions of many respondents whom we interviewed in the field. We frequently heard, for example, that the Navy has particular problems with the new parent fee policy because so many more of their members are in the lowest ranks than is true in other services. Our survey data suggest that distributions of families across fee categories in each service under the new fee policy are very similar.

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[4]Since each fee dollar had to be matched with APF$, fee income had immediate and important funding implications for the military.

[5]However, low fees would not be sufficient to cover wages, forcing a NAF subsidy.

[6]Since some of the results below were sensitive to program size, the data in the remainder of this chapter were weighted by the total number of children in full-time care on an average day.

Table 5.4

Average Fee by Category and Percentage in Each, 1993

Fee Category	Average Fee per Week ($)	Average Percentage of Parents in Fee Category
1	41.92	6.6
2	47.45	52.1
3	60.39	27.9
4	72.51	8.7
5	83.84	4.9

SOURCE: Data from mail survey.

Table 5.5

Average Weekly Fee, by Service

Service	Average Weekly Fee ($)
Air Force	53.03
Army	54.56
Marine Corps	54.19
Navy	53.44
Mean	53.70

SOURCE: Data from mail survey.
NOTE: No. = 193.

Affordability of Child Care

One goal of the MCCA was to make child care more affordable for military families, many of which have relatively low incomes. Although we do not have micro-level data to directly measure how the MCCA affected the affordability of care, we have information about how the new fee policy affected military families with children in center-based care. Our mail survey respondents indicated the extent to which the majority of parents on their installation ended up paying more, less, or about the same for care after the implementation of the MCCA fee policy. In addition, we have data from the civilian sector about the proportion of income spent for child care by parents who use center-based care, which allows us to make comparisons with estimates of what similar military families pay for care.

First, we report on the changes in parent fees reported by the respondents to our mail survey. As shown in Table 5.6, 46 percent of the respondents indicated that parents at their installation ended up paying more, whereas 32 percent indicated that they paid less, and the remaining 23 percent paid about the same. Thus, the effect of the fee policy varied considerably across installations. It also varied by service. As shown in Table 5.7, Army respondents indicated that on average fees declined, while the other three services indicated that fees increased.

Table 5.6

Percentage Reporting Changes in Parent Fees

Change in Fee	Change	Percentage	Cumulative Percentage
Paid less	–1	32	35
Paid about the same	0	23	59
Paid more	1	46	100
Total		101[a]	

SOURCE: Data from mail survey.

NOTE: No. = 227.

[a]Entries do not sum to 100 because of rounding imprecision.

Table 5.7

Amount of Reported Changes in Parent Fees, by Service

Service	Mean	Std. dev.
Air Force	0.33	0.81
Army	–0.18	0.82
Marine Corps	0.20	0.95
Navy	0.25	0.82
Total	0.14[a]	0.87

NOTE: This table was created by converting the response categories (paid less, paid about the same, paid more) to numerical values (–1, 0, 1) and averaging the responses. No. = 227.

[a]Means are significantly different: $p < 0.002$ (F-test).

These results suggest that taken as a whole, military families ended up paying more as a result of the MCCA fee policy. This would imply that affordability had declined, instead of improved, as a result of the MCCA. However, it is important to remember that the DoD was particularly concerned about improving the affordability of care for the lowest-income families, which is why a fee policy tied to income was developed. Thus, it is entirely possible that affordability improved for the lowest-income families while it declined overall.

As noted above, we lack micro-level data on military family income that would allow us to directly determine whether this is in fact the case, but we do have some very interesting data from the civilian sector that enable us to get a sense of the affordability of military child care relative to civilian child care. While these data are not ideal, they are the only data that enable us to contextualize the situation of military families at all income levels after the implementation of the MCCA fee policy.

The data from the civilian sector derive from the National Child Care Survey (NCCS), 1990 (Hofferth et al., 1991), which surveyed a nationally representative sample of U.S. families with children under age 13. Because the NCCS data represent children in many different types of child care, it is necessary to limit the sample to one that is roughly comparable to the military sample. As the MCCA focuses on center-based care for preschool-age children, we consider the results from the NCCS only for children under five years of age. Furthermore, because the NCCS was fielded in 1990 and our survey was carried out in 1993, we have inflated the NCCS expenditure results by the increase in the Consumer Price Index (CPI) between 1990 and 1993 (10.6 percent).[7]

Table 5.8 compares the information obtained from the military and the civilian sector.[8] Of particular interest is the finding that the

[7]Income comparisons between military and civilian families are always somewhat questionable, as military families receive substantial in-kind benefits, particularly housing (or housing allowances). On the other hand, frequent moves by military personnel reduce spouse career progression and thus spouse income.

[8]It should be noted that Hofferth et al. (1991) report child care expenditure estimates separately for employed and nonemployed mothers and considerable differences exist between these groups. For example, 90 percent of employed mothers using center-based care pay for such care, whereas only 57 percent of nonemployed mothers do. As

average weekly fee paid by military families is substantially (almost 25 percent) lower than the average fee paid by civilian families with children in center-based care, even though civilian families typically used care only 38 hours per week as opposed to 50 hours per week for military families.[9]

It is also worthwhile to note that although military CDC fees may have increased overall as a result of the MCCA fee policy, they are still less than those in the civilian sector, both on an hourly and a weekly basis. This is particularly noteworthy because the average quality of care in military CDCs exceeds that in civilian centers, which have not seen the increase in quality brought about by the MCCA in military CDCs and which, with rare exception, are not accredited (see Zellman, Johansen, and Van Winkle, 1994). Thus, from this perspective, military child care is far more affordable than civilian care, given the higher quality of care being purchased on average.

Table 5.8

Average Fees for Center-Based Care for Military and Civilian Families

	Weekly Hours	Hourly Fee ($)	Weekly Fee ($)
Military families	50.0	1.07	53.70
Civilian families	38.3	1.85	70.74

SOURCE: Data from mail survey.

all military parents pay for care in military CDCs, we have used as a comparison group employed mothers with children (under age five) in center-based care. That 10 percent of this sample do not pay for care does not present a problem because they have been excluded from the average fee calculations reported by Hofferth et al. The resulting calculations should therefore provide valid comparisons for the military sample.

[9]Although there are no data kept on the average number of hours of care per day (by children in full-time center-based care), we estimate that children in military day care typically spend 50 hours per week in care. This estimate builds on a number of observations. First, our field data indicate that children in military CDCs are generally expected to be in care 50 hours per week because of the long working hours of military personnel. Furthermore, weekly fees are set based on a 50-hour week, and parents generally understand that they have purchased 50 hours of care weekly. Third, the Navy has a policy of limiting children's attendance in CDCs to 10 hours per day for the child's welfare. Our field interviewees frequently reported requests for waivers from this rule, indicating that it was perceived as constraining.

In addition to this information, the NCCS also reports on the percentage of family income spent on child care, both overall and by income group. We do not have family-specific data to use for comparison, but we can estimate the average family expenditure using information from the military sample together with information from the civilian data to derive average child care expenditure estimates for military families that are comparable to those available from the NCCS. It should be emphasized that because the military data are only estimates, the results should be interpreted with care. In particular, it should be noted that the results we report should *not* be interpreted as evidence regarding individual military families. Such interpretation would require micro-level data, which we do not have. In spite of this limitation, the data do provide a sense of what military and NCCS families with similar characteristics (e.g., type of child care, number of children in care, and family income) pay for child care as a percentage of their income.

To compare average child care expenditures, we need to first estimate the average child care expenditure for military families. This was done by first calculating the total expenditure for a child in full-time center-based care. Because CDCs typically charge for care 50 weeks per year, total annual expenditure may be estimated by multiplying the average weekly fee ($53.70) by 50. Thus, the estimated annual child care cost is $2,685.

Because a certain proportion of families are likely to have more than one child in care, the above-estimated amount is likely to underestimate total annual child care costs. To get a sense of how much to increase this estimate to arrive at the total amount of care, we use information from the NCCS, which shows that total weekly expenditure for a child under age five (in center-based care) is just over $70, whereas total weekly child care expenditure for all children is $84, i.e., 20 percent more. On the basis of these data, we therefore inflate the annual child care expenditures by 20 percent, which assumes that, on average, families have 1.2 children under five years of age in care. Even though military families may actually have a (slightly) different average number of children under five in center-based care, this adjustment is necessary to obtain estimates of expenditures that are *comparable.*

Because military child care fees depend on family income, it is necessary to calculate the average proportion of income spent on child care for each fee category and corresponding income interval (the overall average is obtained by taking a weighted average). However, the income intervals must first be converted to a single number. The most appropriate single number would be the median income of the corresponding income interval. Unfortunately, this information is unknown. As a second-best alternative, we use estimates calculated on the basis of data from the 1992 Department of Defense Survey of Enlisted and Officer Personnel, which included data on family income. This approach is superior to the frequently employed method of using the midpoint of each income interval, because it avoids the problems associated with the latter method (what replacement value to use for the highest-income interval, which is open-ended; and what replacement value to use for the lowest-income interval, the midpoint of which is unlikely to validly represent the median income of that group).

The total annual child care expense for military families using full-time CDC care is estimated at $3,222 across fee categories, with this estimate ranging from a low of $2,847 to a high of $5,030 for the lowest to the highest income category.

When we estimated the percentage of income spent on center-based child care by both military and civilian families,[10] we found that, although military families (with similar characteristics) on average pay lower fees for center-based care than do civilian families, they actually pay slightly more than civilian families as a percentage of total income (12.7 versus 10.1 percent). This average, however, hides

[10]The data on military income were derived from the 5 percent Public Use Sample, 1990 Census, and adjusted for cost-of-living changes between 1989 (the base year) and the year of our survey (1993). The sample was restricted to families in which the military member worked full-time in the base year. Military families who live off base receive a housing allowance that constitutes part of their income. Census studies indicate that people do not always include the value of such allowances in reporting income. Consequently, income may be underestimated and percentages of income devoted to child care overestimated in military families. The civilian data are from the NCCS, which does not report the same income intervals as those corresponding to the MCCA fee categories. We therefore recalculated the NCCS results to match the MCCA income categories. This was done by combining and splitting the reported income categories based on weighted averages (of respondents).

some distributional differences between the military and the civilian sector.

First, the lowest-income group in the military with any families in it—those with income between $11,001 and $27,000—spends a slightly lower proportion of cash income on child care than those in the civilian sector (13.2 versus 14.4 percent).[11] Second, the higher-income groups pay a relatively greater share in the military than in the civilian sector, although the difference is greatest in the middle income ranges ($27,001 to $55,000), where the percentages for military and civilian families are 11.2 and 8.5 percent for fee category 3, 9.3 and 6.9 percent for fee category 4, and 6.9 and 6.0 percent for fee category 5, respectively.

Thus, judging affordability of military child care from the perspective of (estimated) child care expenditures as a percentage of (annual) income, military child care appears to be as affordable for the lowest-income people in the military as it is in the civilian sector, whereas it is slightly less affordable for higher-income families in the military than in the civilian sector.

In conclusion, although we lack data that allow us to reach definitive conclusions about the effect of the MCCA fee policy on the affordability of military child care, we can make some estimates based on available data. The evidence suggests that although cost of care increased for a significant proportion of military families (thus resulting in a decline in affordability), for the lowest-income military families, the fee policy resulted in more affordable care. In comparison to civilian families, military families with annual incomes of more than $27,000 pay a slightly greater share of their cash income for child care.

Effects on CDC Funding

For virtually all CDCs, the cost of care has increased under the MCCA. Better enforcement of child-to-adult ratios and the requirement that each CDC hire a T&C spec have increased costs, in

[11]Fee category 1 (income £ $11,000) is not included because of the 30,940 military families in the 5% Public Use Sample from the 1990 Census, none at all reported income less than $11,000.

some cases dramatically, at the same time that income from fees has declined.

A high-level Pentagon respondent summed up the problem this way: "Raising costs and lowering income to the program (through fee regulations) led me to wonder, 'What are you people (in the DoD) smoking up there?'"

As a result, NAF subsidies became a necessary fact of life in many CDCs in the early implementation period. As noted above, DoD as well as headquarters and major command staff have been active of late in helping COs manage fee-setting and fee income. And NAF subsidies have declined dramatically. But at the beginning of MCCA implementation, respondents agreed, they received very little guidance about fee-setting, the number of needed GS conversions, or even about expectations for subsidies.

In some CDCs, attempts have been made to address the problem of inadequate fee income by choosing to charge at the high end of each fee category. Although this reduces the gap between costs and income from fees and APF$ to some extent, it has not completely closed the gap in most. Moreover, some COs have resisted this solution, either because they want to keep CDC affordable, because they believe that child care should not cost more, or because they want to keep the APF$ commitment to the CDC as low as possible.

A comptroller whom we interviewed focused particularly on the last point. More kids, he noted, increase the required APF$ match. MCCA requirements and lack of new funding on many installations in recent years have resulted in child care getting an increasing proportion of resources during a time of downsizing. Consequently, he said, the CO "can only manage the child care program by opening or closing doors to kids." If the CO is a child care proponent, there will be more slots. "If not," he said, "expect reduced availability."

Another high-ranking respondent told essentially the same tale. As a result of the low fees, she said, "there has been a substantial

reduction in the number of infant slots in the CDCs, since infant care costs the most. Yet the greatest need is for infant care."[12]

On another base, we were told that the same concerns had led the CO to reject the possibility of military construction (APF) funds to build a new CDC. He argued that the increased capacity it would generate would only cost him more in APF$ support and NAF subsidies.

The fiscal shortfall that resulted from the new fee schedule in some instances was exacerbated by uncertainty concerning what was to be included in the match. According to a high-level respondent to whom we spoke, the DoD set the fee schedule on the assumption that costs other than direct costs would not be figured into the match. If such costs were included, then the fee structure plus match would generate too little revenue, and a NAF subsidy would be required to meet CDC costs.

Over time, the services established positions, if not policies, about nonfee NAF funds going to CDCs. Both the Marine Corps and the Navy have adopted a goal that fees and APF$ cover costs, with no need for an MWR subsidy. The Army ran large MWR subsidies for some time but has brought down the subsidies considerably in recent years.[13] The Office of Family Policy has also discouraged NAF subsidies to CDCs. These different approaches are reflected in CDC financial performance. Of the seven CDCs in our 17-installation sample that were running in the black (without an MWR subsidy), five were located on Marine Corps or Naval bases. And three of these five were actually making a profit at the time of our visit.

Continuing Issues

Many fieldwork interviewees wished for more discretion or flexibility in the setting of fees. This discretion would be used to limit subsidies from NAF. Indeed, one comptroller told us that she thought CDP should be just like other category B or C recreation programs, which

[12]See Chapter Thirteen for survey findings concerning increased availability of CDC slots for infants.

[13]See Burrelli (1995), p. 15.

vary user fees to cover costs beyond limited subsidies, e.g., a building. "Why can't they [CDP] charge 80 percent of the outside area [child care fees]?" she asked.

Short of total discretion, a number of respondents would be satisfied with regional fee adjustments.[14] Then, when higher local costs increased the burden on programs, fees could be increased to at least begin to address this gap. Those in low-cost areas asked for similar relief for opposite reasons. They suffer, they said, when costs and salaries for child care in the community can be had for less money, although the quality is certainly lower. This is particularly a problem for older preschool children. In the community, fees are generally lowered as a child ages, since the cost of care declines as child-to-provider ratios increase. In one site we visited, the classrooms for four- to five-year-olds had many vacancies. The CDC director told us that this was a problem for the whole center, since the mean cost of care per child increased dramatically when more-expensive-to-operate infant programs were full and less-expensive-to-operate preschool programs were not.

CONCLUSIONS

One way to deal with the possibility that parents paying higher fees may be motivated by higher fees to leave CDCs for less-expensive care elsewhere is to educate parents about the value of higher-quality care. This will not be easy. RAND research on child care quality (Johansen, 1990; Waite, Leibowitz, and Witsberger, 1991) has shown that convenience and cost are the major factors that parents consider in making out-of-home care choices.

Some attention should also be given to the possibility of allowing fees to vary as a function of real costs, which would lower fees for older children and raise them for younger ones. Under the current fee schedule, where fee limits for infants do not match costs, there is a parental incentive to enroll infants in less-expensive CDCs. Age-based fees would change this incentive and might encourage parents to choose FCC placements for infants, which would be better for them from a health and developmental perspective. At the same

[14]The fee policy does include a high-cost option. Use of this option must be reported.

time, the ability to raise fees for infants might encourage CDCs to supply more infant care, allowing parents more placement choice.

However, raising CDC fees for infants would undermine the goal of affordable care, since it is the lowest-ranked personnel who tend to have the youngest children. One way to deal with these competing issues might be to permit CDCs to impose a surcharge on infants *only if* FCC providers were receiving a subsidy for infant care. This would simultaneously raise CDC fees for infants while lowering them in FCC. This would enable CDCs to collect more realistic fee income for infant care, provide parents with more meaningful choices concerning type of care, and encourage placement of infants in FCC, which is generally agreed to be a superior setting for infants.

Chapter Six

INSPECTIONS AND CERTIFICATION

Inspections have come to be a key component of the MCCA. Listed under Sec. 1505, Subsections (e, f), Child Abuse Prevention and Safety at Facilities, inspections and remedies for violations have come to be the major engine for implementation of the MCCA.

Before passage of the MCCA, inspections were not uniformly carried out. The Marine Corps had no formal inspection program at all. Other services inspected on a regular basis, but even the more rigorous efforts lacked teeth. When violations were found, CDC management and commanding officers were advised to make necessary changes, but there was no system for monitoring remediations and only the most limited sanctions, if any, for failures to improve. Often, violations and deficiencies would be "worked on" for years, and never get resolved. In some cases, less serious problems were ignored.

THE INSPECTION PROCESS

All this changed, and quite dramatically, once the MCCA was passed. Since the MCCA, the inspection process has gained credibility and "teeth." According to one high-level respondent, closures are now accepted without flak; inspectors are perceived to be just doing their job.

The MCCA specified that each CDC be inspected four times yearly, and that the inspections be unannounced. In accordance with guidance from DoD, three unannounced inspections are carried out by installation personnel. These include at least one comprehensive

health and sanitation inspection, one comprehensive fire and safety inspection, and one inspection led by a command representative with authority to verify compliance with DoD standards. This third inspection is to employ a multidisciplinary team with expertise in various health and safety standards prescribed for child care programs.

A fourth, unannounced comprehensive inspection is to be conducted by a high level of command, either a major command or higher headquarters. This inspection includes a review of CDC curriculum, staff, and training, and also an assessment of the safety and appropriateness of indoor and outdoor equipment. Issues that are specifically addressed in the MCCA, such as uses of appropriated funding, child abuse prevention, and creation of parent advisory boards, receive extensive attention in the final DoD inspection requirements. The comprehensive inspection also includes a review of family child care and any subsidiary or part-day programs offered by the installation child development program. Parent interviews are conducted as part of the program evaluation.

The representative designated to perform the fourth program inspection must have expertise in early childhood development and also must meet the validator qualifications required by the NAEYC, the civilian group that accredits both civilian and military child care centers according to its criteria (see Chapter Eleven of this report and Zellman, Johansen, and Van Winkle, 1994, for more discussion on CDC accreditation). These qualifications include either a graduate degree in early childhood development and education or a bachelor's degree in a related field and at least three years of full-time teaching experience with young children. In addition, DoD staff would conduct their own inspections, choosing to inspect one CDC from each service each year.

Inspection reports are sent to the DoD. The results of the four inspections are used by the services to recommend programs for DoD certification. If inspection reports confirm that a child development program is operating in compliance with military standards, DoD issues certification, which is good for one year. Any identified deficiencies must result in immediate corrective action or, in cases of serious violations, closure of the center. If an identified deficiency is not life-threatening, the military department concerned can also au-

thorize the CDC to continue operation by granting a waiver, if the violation cannot be remedied within 90 days, or if major facility reconstruction is required.

DoD inspections rely on a detailed certification checklist. This checklist comprises 13 parts, which include:

- Facility and fire requirements;
- Program;
- Staff-per-child ratios and group sizes;
- Child abuse prevention;
- Staff training and qualifications;
- Food services;
- Funding;
- Certification/inspections;
- Parent participation;
- Health and sanitation;
- Other;
- Family day care; and
- School-age child care.

Each category is rated using a four-point scale. The four scale categories include compliance, partial compliance, noncompliance, and not applicable.

Within the 13 rating categories, items range from the fairly straightforward and bureaucratic to the more qualitative and process-oriented. For example, under food services, one straightforward item asks inspectors to rate that "food service personnel and persons serving food exhibit good personal hygiene and use proper handwashing techniques." A more qualitative item in the same category states, "to the extent appropriate for the age of the children, meals are served family-style and children participate in all phases of the meal service."

Once the ratings are completed, inspectors produce a Child Development Program Certification Report. This report includes summary ratings based on observations in each of the 13 categories. These summary ratings concern deficiencies and range over four categories: no deficiencies, minor deficiencies, major deficiencies, and major, potentially life-threatening deficiencies. Definitions for each type of deficiency are provided. The report concludes with a summary rating concerning deficiencies. In the case of uncorrected major deficiencies, the inspector is asked to certify that an action plan is on file for correcting them in a CDC that remains open. An expected compliance date for correction is entered into the report. For major deficiencies that require closure or partial closure of a CDC, the inspector must indicate that a plan for restoring service exists if the CDC is to reopen, and an expected compliance date is noted.

Remedies for violation were spelled out in some detail in the legislation. With some exceptions, all violations at CDCs were to be remedied immediately. Clearly, "working on it" was no longer an acceptable status, and certainly not for months or years.

The legislation specified that in the case of nonlife-threatening violations, the requirement for immediate remediation could be waived for up to 90 days beginning on the date of the discovery of the violation, but that the violation had to be remedied by the end of that 90-day period. If the 90-day deadline was not met, the CDC would face immediate closure, unless the secretary of the military department concerned authorized the center to remain open. Waivers that permit a CDC to remain open under these circumstances may be granted when the violation cannot reasonably be remedied within 90 days or when major facility reconstruction is required.

As if this were not strong enough, the legislation goes on to require that any closures that result from unremediated violations must be reported to Congress. These provisions have served to dramatically increase Command attention to child care.

A key feature of the inspection process, and one that reflects a keen understanding of the military as an organization, is a postinspection outbrief by the inspection team to the commanding officer at the installation. This outbrief makes the results of the inspection highly visible to the commanding officer and generally increases the visibil-

ity of the CDC as well. Because the inspection results will be made available to the commanding officer's superiors, the commanding officer has a clear stake in receiving a good report and in responding quickly to remediate any identified deficiencies. Indeed, several CDC directors told us that inspection reports are a powerful tool for getting needed and often long-sought-after resources. Some told us that they even point out deficiencies to the inspectors to ensure that they will come to the attention of the commander.

IMPLEMENTATION OF INSPECTIONS

For the most part, implementation of MCCA inspection requirements was relatively rapid. The DoD sponsored training on how to conduct inspections in February 1990. By June 1990, DoD inspection teams were out conducting unannounced inspections. Selection of CDCs to inspect in this first round came from suggestions phoned in on the hot line that is required by the MCCA as a means of facilitating child abuse reporting. Consequently, many of these CDCs were troubled ones. The closures that resulted from the first round of inspections were rapid and dramatic, which lent this aspect of MCCA implementation visibility and force. Closure became an important sanction.

The sanctions worked. By the time of our survey, 80 percent of survey respondents indicated that their CDC was certified.[1] Percentages varied significantly by service, as shown in Table 6.1. More than 80 percent of Army and Navy respondents reported that their CDC was certified; the numbers were lower for the Air Force and particularly the Marine Corps, as shown in Table 6.1. The lower Air Force figure reflects in part their inclusion of accreditation requirements in certification standards.

Not surprisingly, the percentage of respondents indicating that their program was certified was significantly higher among those who reported that their center was accredited. Although we cannot determine the direction of causality here, that the two seem to go together makes sense. Both certification and accreditation processes assess quality, albeit from a somewhat different perspective. And, as

[1]This figure exceeds the certification levels in reports to DoD.

Table 6.1

Certification Status as of 1993, by Service

Service	Percentage Certified	No.
Air Force	74	81
Army	85	66
Marine Corps	46	13
Navy	89	65
Mean	80[a]	225

SOURCE: Data from mail survey.

[a]Service means are significantly different: $p < 0.001$ (F-test).

noted above, at least one service has incorporated accreditation requirements into its certification guidelines. (See Zellman, Johansen, and Van Winkle, 1994, for a detailed discussion of the similarities and differences between accreditation and certification.)

Organizing the inspection teams and providing them with workable standardized inspection checklists was not easy. A major problem that fieldwork interviewees identified was one of proponencies. Because inspections were included in the MCCA, expanded on existing inspection programs in most cases, and examined CDCs, the inspection process was perceived to "belong" to child development. But the other proponencies involved had their own standards and their own timetables. The latter became a major hurdle. Although child development staff had begun to realize that the MCCA implementation timetable was onerous but necessary, this same urgency was not to be found among fire and safety staff in most cases. On a number of bases, they did not put CDP requests for inspections at the top of their priority list.

Even when facility deficiencies were given high priority, repairs could not always be accomplished in a timely manner. A commanding officer at an Air Force base we visited told us that although repair cost was a problem, a more serious constraint in many cases was a lack of personnel who could come out quickly to remedy facility deficiencies.

Nor did other proponencies always adhere to CDP requirements when they did arrive to conduct an inspection. Problems have arisen

at several installations because of ownership issues. On one base, we were told that fire and safety people objected to using a child development checklist as the basis for their inspection. Each year, our respondent told us, the same battle erupts and each year it goes to the commanding officer for resolution. These problems were not caused by the MCCA itself, our respondent continued, but by efforts to implement the law. Child development inspection checklists were designed without input from other proponencies, she explained, and therefore fail to take their concerns and ways of doing things into account.[2] Her suggestion: "If it impacts on fire and safety, they need to tell fire and safety."

Another respondent told a similar story. Initially, inspections were done by child development people. These inspections had led to facility changes, but not enough had been done, according to the engineers who came in later. As a result of the engineers' inspections, more changes had to be made; child development people were upset. In her view, it would have been far better if the engineers had been present at the beginning.

An interviewee at a major command told us that the engineers' absence during early inspections was not surprising, given that engineers are not equipped to make rapid changes. The lack of any funds from the MCCA or from child development to engineering staff reinforced their tendency not to respond quickly. Overall, this respondent contended, the importance of other functional areas in the implementation of the MCCA failed to be recognized, and this substantially slowed the process, particularly with regard to facility changes.

The same respondent provided an example of a proponency problem that had occurred on one of the major command's installations. CDCs were required to have hospital-grade cleaning services. But such services were hard to obtain because engineering, which provided janitorial services, had suffered cutbacks. Engineering insisted that child development pay for these services. Child development could respond in one of two ways: (1) pay for the service with NAF$, or (2) "reprogram" APF$. But use of APF$ caused problems. Engi-

[2]DoD interviews told us that at the DoD level, there *was* such coordination. But obviously, this coordination was not occurring at the local installation level.

neering would have to give CDP a credit (Management Decision Package—MDEP) for the cost, which was contrary to Army policy. Here, at least, our respondent noted, someone had paid attention to proponency issues, and engineering had been instructed to provide the credit.

Payment and budget shortfalls have dogged the inspection program just as they have dogged other aspects of child development programs. For example, on one base, the commanding officer decided that he needed to recoup some of the increasing percentage of base operations funds that was flowing to CDP as their mandates remained in place while dramatic cutbacks had occurred in the overall base budget. So, he decided to begin direct charging the CDC for services that had previously been provided gratis. It was for this reason that at the time of our visit, CDC staff were gearing up to cut their own grass. Some CDCs were also faced for the first time with the need to pay for the nurse who would conduct the health inspection for the CDC. CDCs in other locations were also paying for fire and safety inspections, and for custodial services, as discussed above.

Like many other aspects of the MCCA implementation process, inspection requirements were slow in coming but fast to change. At one Air Force base that we visited, the MWR director told us that the inspection criteria change each time that there is a no-notice inspection. When we interviewed in March 1993, MWR had just received a new checklist, which made the checklist used for the September 1992 inspection out of date. "The Air Force keeps changing the checklist. Each checklist requires changes," he complained. For example, the Air Force divided the fire and safety inspection into several components, including a one-time structural fire safety inspection, an annual operational fire safety inspection, and an annual operational safety inspection. In a few instances, these changes were both well thought out and salutary. For example, at one point the Air Force decided that it would incorporate accreditation requirements into the inspection protocol. This would reinforce the Air Force's universal accreditation mandate. By integrating accreditation requirements with inspection checklists, the inspection process would help CDCs prepare for required accreditation.

CERTIFICATION

Achievement of certification did not come easily in many cases. Almost half of our survey respondents (47 percent) indicated that it had been difficult or extremely difficult to make the facility changes required by the inspections specified in the MCCA. Almost three-quarters (74 percent) described these changes as at least somewhat difficult. Average difficulty of making required facility changes (with 1 = extremely difficult and 5 = not at all difficult) is shown in Table 6.2 by service. Differences across services were significant. As the table shows, Marine Corps respondents reported much more difficulty than respondents in other services, a finding that is supported by what we heard during installation visits, discussed in more detail below.

Program changes did not come easily, either. A similar percentage of survey respondents indicated that program changes were difficult or extremely difficult (41 percent), and 73 percent described such changes as at least somewhat difficult. Average difficulty of making required program changes is shown in Table 6.2 in column 2 by service. Comparing across ratings for facility and program changes,

Table 6.2

Difficulty Rating for Required CDC Facility and Program Changes, by Service

Service	Facility Changes	Program Changes	No.
Air Force	2.3	2.5	86
Army	3.1	3.0	66
Marine Corps	1.7	2.3	13
Navy	3.1	3.2	71
Mean	2.7[a]	2.8[a]	236

SOURCE: Data from mail survey.

NOTE: Cell entries are average change difficulty scores, with 1 = extremely difficult and 5 = not at all difficult.

[a]Differences between services are significant: $p < 0.001$ (F-test).

we see enormous similarity, both in rankings across services and in absolute numbers. The only exception is program changes for Marine Corps respondents; these appear to have been less difficult to accomplish than facility changes, a distinction noted by several Marine Corps interviewees during installation visits.

Additional survey data point to fairly rapid implementation of inspections and certifications. We asked respondents whose programs were certified to tell us when their program was certified. As shown in Table 6.3, we found significant differences across services in the time of certification.[3] Navy programs on average were certified the soonest, and Marine Corps programs took the longest to be certified.

Once again, we found that accreditation makes a difference: Accredited centers were certified significantly sooner, although we cannot determine whether meeting inspection requirements facilitated accreditation or the obverse.

As noted above, 80 percent of respondents indicated that their program was certified. We asked those with uncertified programs to indicate the reasons why their program was not certified, and offered facilities, program, or other categories. Of the 50 respondents who indicated why their program was not certified, nearly half (48

Table 6.3

Average Date of DoD Certification, by Service

Service	Average Certification Date
Air Force	July 1992
Army	June 1992
Marine Corps	February 1993
Navy	March 1992
Mean	June 1992[a]

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.04$ (F-test).

[3]To run a test of statistical significance, certification dates were converted into months.

percent) indicated that the reason was facility problems. Thirty percent indicated that program deficiencies had prevented certification, and 34 percent gave "other" reasons for lack of certification.

An analysis by service revealed that the proportion of respondents indicating that facility problems were the reason for lack of certification varied significantly and dramatically by service. As shown in Table 6.4, the Army reported the fewest facility problems, and the Navy and Marine Corps the most.

In contrast, program problems were most often cited as the reason for lack of certification by Army respondents, with Air Force respondents close behind, as shown in Table 6.4. Program problems were not often cited by Navy and Marine Corps respondents as reasons for lack of certification. This may simply reflect the much higher facility problem ratings in these services: Facility problems may be easier to identify, and once identified, preclude both certification and concerns about program.

Center closures were the tool that reinforced the MCCA's inspection requirement. We asked respondents to our survey to indicate whether any centers on their installation had been closed as a result of an inspection. Not surprisingly, most (92 percent) answered no. We then looked at the distribution of yes responses by service.

Table 6.4

Percentage of Respondents Indicating That Facility, Program, and Other Problems Precluded Certification, by Service

Service	Facility Problems	Program Problems	Other Problems	No.
Air Force	48	43	24	21
Army	18	45	55	11
Marine Corps	67	0	33	6
Navy	67	8	33	12
Mean	48	30[a]	34	50

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.09$ (F-test).

We found that the range—from 18 percent of Marine Corps respondents to 2 percent of Navy respondents—was not significantly different across services.

We then looked to see if the closures captured in our sample had occurred as a result of different types of inspections. Our data indicate that the proportion of respondents who indicated that a closure had occurred in response to a headquarters inspection did not vary across service. However, Navy and Marine Corps respondents were significantly more likely to indicate that a closure had occurred in response to a headquarters inspection than were Army and Air Force respondents.[4] In contrast, 79 percent of Army respondents told us that a closure had occurred in response to a major command inspection; the comparable figure for Air Force respondents was 34 percent. (Since the Navy and Marine Corps do not have major commands, these cells were empty.) Local inspections accounted for one-third of reported Marine Corps closures. Comparable figures for the other services were significantly lower and in the range of 0–5 percent.

EFFECTS OF INSPECTIONS

The effects of the new inspection requirements were immediate and dramatic. As noted above, the closure of several CDCs caused an immediate furor in the ranks, and a flurry of activity ensued that was designed to avoid additional closures. The services varied, however, in their approach to avoiding a poor inspection report. In the Air Force, it became known fairly quickly that a high-level uniformed officer was closely monitoring inspection reports and was exhibiting limited tolerance for poor performance. Waiver requests flooded in, but they often were greeted skeptically by this officer. He indicated frequently that he would have to see strong evidence of efforts to meet the requirements before such requests would be granted. For the most part, Army CDCs were in relatively good shape, due to years of fairly high levels of spending. The Marine Corps did not have a program of inspections in place at the time that the MCCA passed.

[4]This probably reflects the greater use of sanctions before the MCCA in the Air Force and Army than in the Navy or Marine Corps. The Army closed CDCs before enactment of the MCCA.

Many CDC directors found that repairs that they had been wanting to make for years, but could not get approval or funds for, were now scheduled, and got done. Savvy directors took to reminding commanding officers of pending inspections when they asked for equipment or supplies. One particularly strategic director kept a list of needed equipment and repairs. She would point out these things to inspectors when they visited; they would then appear in the inspection report as deficiencies needing remediation. Overall, noted one Marine Corps child development manager, inspections and closures gave child care "extra clout."

In Air Force headquarters, the deluge of waiver requests that resulted from the early rounds of inspections was carefully monitored with an eye to serious need versus recalcitrant delay. In one instance, for example, an OCONUS CDC had been cited for inadequate playground equipment. The commanding officer asking for the waiver contended that they could not get the equipment shipped over from the United States in time to meet the 90-day requirement. The commanding officer was told to find a local supplier. A subsequent communication revealed that that was exactly what was done.

Survey data support the contention that inspections have had a major effect on CDC quality. Respondents were asked to indicate first whether inspections had helped their program and in what ways. Then they indicated whether inspections had hurt their program in a variety of ways. Responses were overwhelmingly positive. Indeed, less than 2 percent of respondents indicated that inspections had had no beneficial effects on their program.

Most respondents reported multiple positive outcomes. As shown in Table 6.5, more than half of respondents indicated that inspections had increased command attention and program resources and had resulted in much-needed repairs or renovations being made. Most also believed that inspections had improved the ability of child development staff to evaluate program quality.

This rosy picture was not true everywhere, nor was it completely rosy. On some installations, facilities were in such bad shape and renovation funds were so limited that repairs could not be made, and closures ensued. This was particularly true on Marine Corps installations, where CDCs were often housed in older buildings con-

structed for other purposes.[5] When closures occurred, availability declined drastically. But even when CDCs were not closed, inspection requirements, and particularly those pertaining to facility changes, posed challenges.

A few fieldwork interviewees spoke directly to these negative effects of inspections; noted in particular were the heavy burdens imposed on staff by follow-up activities required by inspectors. A few respondents talked about the rigidity of the inspection process. Some accepted this as a cost of improving quality, but others found it hard to accept. Morale problems from inspections that heavily focused on deficiencies and failures were noted as well. (Indeed, a number of fieldwork interviewees contrasted the negativity of inspections with the positive tone of the validation visits required for accreditation. These visits, respondents agreed, focused on progress and on positive accomplishments.) (See Zellman, Johansen, and Van Winkle, 1994, for further discussion of this point.)

Table 6.5 displays the benefits of inspections that survey respondents described. What is perhaps most interesting about Table 6.5 is the general lack of interservice differences. Most respondents, regardless of service, perceived that inspections had improved physical plant, level of resources, and program capacity; the latter in the form of increased staff ability to assess and understand program quality. An analysis (not shown) confirmed these cross-service similarities. It found that the average number of benefits accruing from inspections (mean across services = 2.8) did not differ by service.

We also asked respondents to describe the ways in which inspections might have hurt their programs. Half (51 percent) indicated that inspections had not hurt their program in any way. Those who believed that inspections had been harmful in some way were most likely to say that they had been harmful because the number of spaces had been reduced. Fieldwork interviewees expanded on this point. They noted that closings of sections or whole centers had reduced the number of CDC slots. Strict enforcement of ratios meant that capacity declined, even when centers did not experience closure.

[5]The lower level of support to Marine Corps CDCs reflects a Marine Corps bias against support for families (Builder, 1996).

Table 6.5

Percentage of Respondents Reporting Specific Benefits of Inspections, by Service

Service	Increased Program Resources	Increased Command Attention	Repairs Made	Staff Skills Better
Air Force	57	84	77	64
Army	51	88	81	58
Marine Corps	46	77	77	69
Navy	57	76	63	57
Mean	55	83	74[a]	60

SOURCE: Data from mail survey.

[a]Differences between services significant: $p < 0.006$ (F-test).

Reported inspection outcomes did vary by service, as shown in Table 6.6. In particular, we found substantial differences across services in perceived negative effect of inspections on program availability and popularity. Not surprisingly, Marine Corps respondents scored high on both, reflecting the substantial changes that had to be made in Marine Corps CDCs under the new inspection requirements. For example, before the MCCA, Marine Corps policy permitted CDCs to exceed established ratios by 50 percent. New policy established in response to the MCCA rescinded such permission.

Table 6.6

Percentage of Respondents Reporting Specific Negative Outcomes of Inspections, by Service

Service	Reduced Resources	Increased Command Attention	Fewer Spaces	Program Less Popular
Air Force	1	14	33	27
Army	0	12	5	17
Marine Corps	0	23	31	31
Navy	0	3	21	7
Mean	0	11[a]	22[a]	19[a]

SOURCE: Data from mail survey.

[a]Differences between services significant: $p < 0.01$ (F-test).

Table 6.7 makes these findings even clearer. The average number of negative effects of inspections that respondents endorsed varied substantially by service, with Marine Corps respondents indicating significantly more.

On balance, respondents agreed that the effect of inspections was overwhelmingly positive. As shown in Table 6.8, the average difference between the number of positive effects cited minus the number of negative ones was positive in every service. Although the balance in the positive direction was least for Marine Corps respondents, differences by service were not significant.

Table 6.7

Average Number of Negative Effects of Inspections, by Service

Service	Mean Negative Effects	No.
Air Force	0 89	81
Army	0.47	60
Marine Corps	1.08	13
Navy	0.36	61
Mean	0.63[a]	215

SOURCE: Data from mail survey.

[a]Means significantly different: $p < 0.0000$ (F-test).

Table 6.8

Mean Effects of Inspections, by Service

Service	Mean Positive Effects Minus Mean Negative Effects	No.
Air Force	1.98	81
Army	2.27	60
Marine Corps	1.69	13
Navy	2.28	61
Mean	2.13[a]	215[a]

SOURCE: Data from mail survey.

[a]Differences between services not significant (F-test).

CONCLUSIONS

Inspections have come to be a key instrument of MCCA implementation. Regular inspections with teeth put the services on notice that standards, which in many cases predated the MCCA, henceforth would be enforced. Several CDC closures resulting from the first round of inspections, which included DoD personnel, effectively conveyed this message.

Selection of the early-inspected CDCs depended on tips coming from parents and staff to an MCCA-mandated hotline, included in the legislation to promote reporting of suspected child abuse. The hotline remains an important tool in enforcing compliance.

The inspection process has also been facilitated by an exit interview with the installation commander at the conclusion of each inspection visit. There, problems are identified and the need for remedies discussed. Active involvement on the part of high-status individuals has also facilitated progress. Hard scrutiny of all requests for waivers of strict remedy schedules and the rejection of many such requests have speeded improvements, particularly in the Air Force.

The DoD's certification checklist did much to clarify what it takes to run a high-quality program in a high-quality facility, which has been helpful systemwide. Although some resent the time and material costs incurred in bringing CDCs up to standard, survey respondents were clear that the inspection process has been very beneficial. Inspections have resulted in increased program resources, increased command attention, improved facilities, and better staff understanding of what constitutes a quality program.

We turn now to an analysis of another MCCA component that has enormously improved the system, training and curriculum specialists.

Chapter Seven

TRAINING AND CURRICULUM SPECIALISTS

One of the most important aspects of the MCCA from an implementation perspective was the requirement that each CDC hire a T&C spec.[1] This person would be key to successful implementation of the MCCA for three reasons.

EXPERTISE

First, the person hired into the position had to have a minimum of a bachelor's degree in early childhood education, child development, or a related field of study, and experience in working with young children in a group program, or a graduate degree in early childhood education or child development. These requirements meet the standards for the Early Childhood Specialist position established by the National Academy of Early Childhood Programs, the accrediting arm of the NAEYC. In some locations, and particularly where the CDC director did not have a bachelor's degree in child development, the T&C spec substantially increased the level of on-site knowledge upon which CDC staff could draw. As Palumbo and Calista (1990) remind us, expertise can be a source of power for implementors of new programs. T&C specs became connected to a network of professionals through their accreditation-seeking activities and were able to justify MCCA and accreditation requirements on the basis of child development theory, research, and practice. In most CDCs, education and training made the T&C spec the most knowledgeable person in the

[1] A number of Army CDCs employed a person who fulfilled the role of a T&C spec before the passage of the MCCA.

center concerning child development. T&C specs had a job description that was highly compatible with the key MCCA goals of quality care. As noted in the DoD Implementing Guidelines for the MCCA (3/23/90), T&C spec duties include:

1. Special teaching activities at the center;
2. Daily oversight and instruction of other child care employees at the center;
3. Daily assistance in the preparation of lesson plans;
4. Assistance in the center's child abuse prevention and detection program;
5. Advising the director of the center on the performance of other child care employees;
6. Developing or selecting age-appropriate curriculum and staff training materials;
7. Ensuring that equipment and materials are available to complete activities;
8. Ensuring that staff receive training opportunities required for promotion and upward mobility;
9. Ensuring that all staff receive, comprehend, and demonstrate skills as a result of required training; and
10. Coordinating off-base training opportunities and serving as liaison with professional organizations.

ADVOCACY

Second, given their background and job description, each T&C spec immediately became an advocate for and committed implementor of the MCCA, whose goals were to improve staff training and increase staff knowledge of key child development concepts and improve the delivery of developmentally appropriate care.

INCREASED ORGANIZATIONAL CAPACITY

Third, the T&C spec's job description allowed her time—free of direct caregiving or in many cases administrative burdens—to develop a staff training curriculum, to provide caregivers with support in their efforts to design and implement an appropriate developmental curriculum, and to attend to other aspects of MCCA implementation, such as accreditation. This more flexible time that T&C specs had was fairly unique in CDCs. In contrast, caregivers must remain with children unless relieved by an adult; directors everywhere told us that running the CDC took every minute of their time. Thus, T&C specs provided CDCs a unique resource: increased organizational flexibility and capacity.

As Goggin et al. (1990) note, organizational capacity is a key aspect of successful implementation. In some sense, the T&C spec position increased organizational capacity by building some degree of flexibility into each CDC where little or none had existed before. Although each T&C spec's workload was significant, how she organized it was under her control to a far greater extent than was the case for anyone else working in the CDC. Indeed, the T&C spec was a major player in the accreditation of most CDCs that were accredited by the time of RAND staff visits. For example, T&C specs often redesigned the content and process of training to focus on and strengthen program deficiencies identified through the self-study process. She was able to take on this task by essentially redefining her job as the facilitator of CDC accreditation during the self-study period and the period when preparations were under way for the validation visit. In most CDCs, the T&C spec was the only person who could do this.[2]

T&C SPEC EFFECTS

In most of the sites that we visited, staff reported that the presence of the T&C spec had contributed significantly to improved curriculum design and staff training. Caregivers nearly everywhere told us that

[2]CDC directors everywhere were actively involved in accreditation, but their many other responsibilities did not permit them to redefine their job, as T&C specs often did. See Zellman, Johansen, and Van Winkle (1994) for additional discussion of the T&C specs' role in CDC accreditation.

the MCCA, which was largely interpreted and delivered by the T&C spec, had resulted in substantial changes in how they interacted with children, arranged their rooms, and understood their work. One CDP director told us that the new training regimen that the T&C spec had implemented had substantially increased staff motivation and the quality of caregiving.

In most cases, the promise that training and curriculum specialists brought to CDCs has been more than realized; the T&C spec adapted training and curriculum materials from HQ and MACOMs to local needs and in some cases developed new materials as well. Most also set in place a process for monitoring curriculum delivery and staff training that ensured a developmental focus. One T&C spec whom we interviewed told us that the major bonus that the position provides CDCs is that the T&C spec has the time to actually do training. Before T&C specs arrived on the scene, already overworked CDC directors were expected to handle training along with everything else. Few were able to give training the time it deserved. Moreover, this same respondent told us, expecting CDC directors to train creates a difficult dual relationship that reduces the value of training: During training, the trainer asks people to admit and work on their weaknesses. If the trainer is also the CDC director—the person who will evaluate you—staff may be reluctant to reveal such weaknesses.

Another advantage that T&C specs brought to CDCs was their ability to function as Child Development Associate (CDA) advisors to caregivers. The military's modularized training enables caregivers to apply for a CDA credential after completion of the 13 required training modules. The CDA credential, which is popular among child care center staff in the civilian sector, increases the portability of training, particularly from the military to the civilian sector. In some instances, the T&C spec was able to motivate caregivers to keep going after they achieved their CDA credential—we heard stories in many places of caregivers who had gone on to complete bachelor's degrees in child development.

Our site visit data also reveal that T&C specs played a crucial role in CDC accreditation in nearly every center that successfully completed that process post-MCCA. The T&C spec's role in accreditation was even more crucial when the CDC director lacked a background in child development. The T&C spec's expertise and her ability to rede-

fine her job for a time as facilitating accreditation made her presence essential in the process. Indeed, in one center that we visited, failure to achieve accreditation was attributed in large part to the departure of the T&C spec just before the validation visit.

Despite their positive effect on staff training and curriculum development nearly everywhere, T&C specs were not always popular with Command. In a number of places, we encountered command respondents who believed that they were an unnecessary frill. On one installation, the MWR director described T&Cs as "staff glut." A like-minded colleague on another installation suggested that there be a standardized curriculum throughout the Navy so that there would be no need for T&C specs.

Even in some CDCs, T&C specs received less than an enthusiastic welcome, at least at first. One T&C spec whom we interviewed told us that CDC caregivers were very hostile to the idea of her coming into their classrooms and wanting to train them. But she persevered. Colleagues in other locations reported a similar phenomenon.

Some of the hostility to T&C specs reflected resistance to new training requirements and, for some, to the idea that caregiving requires more than the most minimal training. In one site, staff were highly resistant at first to the new MCCA training requirements. However, all fell into line when they learned that they would be fired if they did not complete the training modules in the specified timeframe. In another site, the CDC director was preparing to fire 10 percent of caregivers at the time of our visit because they had not completed required training during the time allotted.

The inclusion of T&C specs on the staff of every CDC was a means that Congress employed to improve training materials and curriculum design and to ensure that staff met training requirements. One measure of the effect of T&C specs is whether there were changes made to staff training materials as a result of the MCCA. We asked survey respondents, "Have you made changes in the content of your staff training program in response to the MCCA?" As shown in Table 7.1, the vast majority of respondents reported that they had made such changes. As Table 7.1 shows, the percentage indicating that changes had been made varied by service, with differences significant at the 0.007 level (Chi-square). Air Force respondents were the

Table 7.1

Percentage Reporting Changes in Staff Training Content in Response to the MCCA, by Service

Service	Percentage Indicating Change	No.
Air Force	93	83
Army	88	67
Marine Corps	92	13
Navy	74	69
Mean	86[a]	232

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.007$ (F-test).

most likely to report having made such changes; Navy respondents were the least likely to report them.

It is difficult to interpret the reasons for lack of changes. Some lack of change reflects the existence of good materials; the relatively low level of change in the Navy no doubt reflects the early use of training modules by the Navy. The Navy developed and used the 13 training modules first; a trainer helped staff complete them. Army T&C spec respondents to whom we spoke in the field often indicated that they were pleased with the materials provided by HQ, which the Army got from the Navy. The difficulty that some installations continued to experience in hiring qualified T&C specs may also have contributed to a lack of change in training materials even if those materials were in need of change. The key finding, however, is the positive one—a record of widespread change in training materials as a result of the MCCA.

The most frequently reported changes in the staff training program were a better structure for the training (56 percent), better content (28 percent), and more hours of training (26 percent). The improved structure for training that was reported by the mail survey respondents includes new training modules, small group observations, and T&C spec inputs. The improved content involves such activities as better age-appropriate training, CDA preparation, and college courses. A few respondents (5 percent) also reported that the staff

training program had been changed to include child abuse prevention.

The reported changes in the staff training program are all changes that ought to lead to improvements in the quality of caregiving, which was the intent of this provision of the act. To test more directly whether the changes in the staff training program actually resulted in an overall improvement in the quality of care provided at CDCs, we asked the mail survey respondents to rate changes in the quality of care that resulted from the implementation of the MCCA staff training requirements. As Table 7.2 shows, 95 percent of all respondents reported some or big improvements in quality of care.

To investigate possible differences across the four services in the perceived effect of the new staff training requirements, we assigned a numeric value to each category. These values may be found in column 1 of Table 7.2. These values were used to calculate the average rating of quality improvements resulting from implementation of the MCCA staff training requirements in each service (see Table 7.3).

Marine Corps and Air Force respondents report the biggest improvements in overall quality of care as a result of the MCCA staff training requirements. This is not surprising given that the Navy had more developed training programs before the implementation of the MCCA; the Army adopted the Navy modules for its own use. The Army had the equivalent of T&C spec positions before the MCCA, which is likely to be part of the explanation for why this provision of the act has had less effect on quality of care in the Army than in the other services.

Table 7.2

Changes in Quality of Care Due to MCCA Staff Training Requirements

Change in Quality		Frequency	Percentage	Cumulative
Some decline	–1	1	0	0
Little or no change	0	10	4	5
Some improvement	1	69	30	35
Big improvement	2	150	65	100
Total		230	100	

SOURCE: Data from mail survey.

Table 7.3

Average Quality Improvement Rating Resulting from MCCA Staff Training Requirements, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.71	0.48	83
Army	1.48	0.69	64
Marine Corps	1.69	0.48	13
Navy	1.58	0.63	70
Mean	1.60[a]	0.60	230

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.11$ (F-test).

STRUCTURAL LOCATION

To whom the T&C spec reports appears to be an important factor in how effective she can be in promoting developmental care and ensuring universal staff compliance with training requirements. Sometimes, she reports to the CDC director; sometimes to the child development coordinator on the installation. On some Air Force bases, she reports to the youth support flight chief, who is responsible for child development and youth programs. Our site visit data suggest that when the T&C spec reports to the CDC director, her power to bring about change is reduced because the CDC director herself does not have much clout. Low GS ratings for administrators, which were not addressed in the MCCA, contribute to a lack of authority on the installation among CDC directors, according to several interviewees. Indeed, a number of CDP staffers mentioned the need to increase the status and salary of CDC directors in response to our question about what, if anything, should change about the MCCA. A few T&C specs told us that the boss's (the CDC director's) lack of child development background made it difficult to convince her of the importance of some T&C spec activities. In one instance, the T&C spec's role as change agent and MCCA advocate and implementor was constrained by the CDC director's own resistance to the changes that the MCCA required.

In some contrast, T&C specs who reported to the child development director or to the youth support flight chief described themselves as having much more authority and autonomy in the system.[3] This was largely because their immediate boss herself or himself was more powerful.

SCOPE OF WORK

The dimensions and demands of the T&C spec job depended to some extent on the service in which a T&C spec worked. Some HQ training modules provided T&C specs with considerable help and guidance. They also contributed to both a minimal level of competence in training activities and some level of uniformity across CDCs and installations in terms of what caregivers were learning and were expected to know. In other services, T&C specs told us that the materials were not adequate and required a good deal of work to make them training-ready.

The scope of the T&C spec job varied by service as well. In the Army, for example, FCC providers have their own T&C spec, so that T&C specs assigned to CDCs are not expected to train or monitor FCC providers. In the other services, T&C specs provide training and support to FCC providers to varying degrees.[4]

Differing policies by service with regard to training also affect T&C spec job requirements. For example, the Army requires that each CDC caregiver have an Individual Education Plan (IEP). This plan specifies the caregiver's training and education goals and achievements. Army T&C specs must develop these plans.

Job demands also varied as a function of how services for children were organized on the installation. For example, on Air Force bases with a youth support flight chief, T&C specs were beginning to spend some of their time working with youth staff at the time of our visits. In the Army, T&C specs used some CDC training materials to train FCC providers.

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[3]The T&C spec now reports to the youth flight chief on all Air Force bases.

[4]For example, after an Air Force CDC is accredited, T&C specs are directed to work with FCC and school-age programs as well.

HIRING

Hiring of T&C specs was not always easy. In some locations, and particularly OCONUS, people with the requisite background and training were not readily available. In a number of places, T&C specs had backgrounds in areas other than child development, such as elementary education. Lack of a child development background reduced T&C spec effectiveness in a number of instances. In many places, the problems associated with hiring GS staff came into play in hiring of T&C specs, although since the position was new, staff were able to skirt the NAF-GS conversion process, which is discussed in more detail in Chapter Eight.

We asked survey respondents whether all T&C spec positions on their installation were currently filled. Seventy-four percent of respondents indicated that they had filled all of these positions. These percentages differed significantly by service at the 0.05 level (F-test). As shown in Table 7.4, Marine Corps respondents reported the highest percentage of T&C positions filled, and Army respondents reported the lowest number. It should be noted that the Army respondents had to hire a larger number of T&C specs, which accounts at least in part for the greater percentage of such unfilled positions. In addition, the Army has created more T&Cspec positions than required; consequently, a higher rate of unfilled positions does not necessarily signify failure to meet regulations.

Table 7.4

Percentage T&C Spec Positions Filled, by Service

Service	Percentage Filled	No.
Air Force	79	86
Army	63	65
Marine Corps	92	13
Navy	75	65
Mean	74[a]	229

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.05$ (F-test).

We hypothesized that one factor that might affect whether or not a T&C spec was working in a center would be that center's accreditation status, since we had found that T&C specs were crucial to successful accreditation in most instances. However, analyses of the percentage of T&C spec positions filled by accreditation status revealed that whether or not a CDC was accredited did not affect the likelihood that all T&C positions were filled. This may reflect a ceiling effect; respondents reported that most such positions were filled at the time of the survey.

Those survey respondents who indicated that not all T&C positions were currently filled were asked to indicate the reasons why these positions were open. The most commonly reported reason for open positions was "difficulties hiring GS staff," a topic that we address in more detail in the next chapter. Thirty-eight percent of respondents who indicated that one or more T&C spec positions were currently open gave this reason for the unfilled slot. Lack of funds and lack of qualified staff were each endorsed by 13 percent of respondents reporting open T&C spec positions as reasons why the positions were unfilled.

CONCLUSIONS

The T&C spec provision was a key aspect of MCCA implementation, as it ensured that there would be at least one well-trained child development specialist working in each CDC. Her expertise could be relied upon when needed to facilitate MCCA implementation. Her commitment to training ensured that it was given adequate attention, often for the first time.

Of equal significance, the required T&C spec position increased the level of organizational capacity in CDCs. Given strict ratios that govern caregiver mobility and heavy administrative burdens on CDC directors, the T&C spec was often the only person in the CDC who could control her work flow. This proved to be invaluable in facilitating the CDC accreditation process.

Our data suggest that T&C specs have had a positive effect on staff training. Nearly all survey respondents indicated that the content of staff training had changed; at least some of this was due to the work

of the T&C specs. And in many CDCs, the T&C spec inspired caregivers to get CDA credentials and be proud of their work and their profession—key factors in improving the quality of care.

Chapter Eight

GS POSITIONS

To achieve the increased child care capacity that was a major legislative goal, the MCCA required that more caregivers be hired. Since an additional goal of the MCCA was to increase the flow of APF$ to CDPs, many of these new positions needed to be appropriated funds positions. Congress recognized the importance of these goals by specifying in the MCCA, Section 1503, subsection (f) that:

> The Secretary of Defense shall make available for child care programs of the Department of Defense, not later than September 30, 1990, at least 1,000 competitive service positions in addition to the number of competitive service positions in such programs as of September 30, 1989. During fiscal year 1991, the Secretary shall make available to child care programs of the Department additional competitive service positions so that the number of competitive service positions in such programs as of September 30, 1991, is at least 3,700 greater than the number of competitive service positions in such programs as of September 30, 1989.

The law indicated that managerial and training positions were to be targeted, as described above. But the sheer volume of positions dictated that many would be direct care positions. Although a Marine Corps document dated May 6, 1992, indicated that CDC caregivers were at the bottom of a priority list of 12 positions that should be converted under the MCCA, the document made clear that "child development program assistants (positions) may also be competitive service . . . ."

COMPETITIVE SERVICE POSITIONS

The large volume of new positions were to be competitive service (also referred to as general schedule or GS) positions. These positions are very different from the nonappropriated funds (NAF) Patron Service (PS) positions that were held by the vast majority of caregivers in CDCs before the passage of the MCCA. NAF positions may draw on funds generated from within the CDC (these are almost exclusively parent fee revenues) and funds generated from outside the CDC. This latter category includes military exchange dividends or dividends from civilian recreation and/or welfare funds. Transfer of these funds, although a common practice, is not always a popular one, as discussed below.

GS and NAF positions come under different administrative entities and thus hiring, working conditions, promotions, and retentions in these jobs must comply with different rules. In general, NAF positions are less bureaucratic and rule-bound. They allow employers a good deal of flexibility in hiring, scheduling, and promotions. NAF jobs tend to be relatively low-paying and provide few, if any, benefits.

Indeed, part of the impetus for higher caregiver wages and GS positions grew out of concerns about the staffing of CDCs before the MCCA. Some NAF employees worked split shifts to cover early morning and late afternoon times which regular shifts did not cover, or they worked only during the time of the day when the census was highest. Often, these employees were sent home when fewer children than expected arrived for care.

These practices, all perfectly legitimate for NAF employees, contributed to a high rate of transition for children from one caregiver to another over the course of the day. They also contributed to low incomes for these flexible caregivers which, in turn, contributed to high turnover rates among them.

We asked survey respondents about the use of flexible-hour employees in the CDC before the MCCA, and at the time they completed the survey. As shown in column 1 of Table 8.1, flexible-hour caregivers were fairly common before implementation of the act, with about 40 percent of caregivers DoD-wide in the flexible-hour employees category. Air Force CDCs employed the highest percentage of flexible-hour employees.

Table 8.1

Percentage of Flexible-Hour Employees Among CDC Caregivers, Pre- and Post-MCCA, by Service

Service	Pre-MCCA	No.	Post-MCCA	No.
Air Force	53.1	65	25.9	85
Army	30.2	48	20.4	64
Marine Corps	16.6	10	34.1	13
Navy	33.4	53	31.0	70
Mean	38.8[a]	176	26.4[a]	232

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.02$ (F-test).

At the time of our survey, the overall percentage of flexible-hour employees in CDCs had declined to about one-quarter, as shown in column 3 of Table 8.1. With the exception of the Marine Corps, where the percentage of flexible-hour employees doubled after the act, there was a decline in reported use of these employees.

GS jobs generally pay better and are more secure. However, because of the enormous range of GS jobs, CDC caregivers are not a unique category. Consequently, education and skill requirements for jobs at the level of caregivers may poorly match skills and experience needed to provide high-quality care to young children. As a result, some CDCs have found themselves reviewing applicants for caregiver jobs whose entire background and experience is in secretarial work. In some of these cases, neither prospective employer *nor* employee was interested, but the system provided no way to avoid such mismatches. However, some services made efforts, described below, to solve this problem.

The increased number of positions that the law stipulated would certainly help in the implementation of the MCCA. Some of the very requirements designed to improve quality, such as stricter monitoring of child-to-caregiver ratios, would require additional staff just to keep enrollments constant. Additional staff would be necessary to increase availability, which was also a Congressional goal. The fact that these positions were competitive service positions conferred additional burdens and rewards on child development managers and caregivers. Indeed, many of our respondents described the conver-

sion of NAF caregivers to GS positions as one of the most difficult aspects of the MCCA.

Competitive service positions promised to confer a range of advantages on those who attained these positions. Most important, GS positions provide their holders with improved benefits and greater job security. Like other government service positions that are sought out in part because of guarantees of lifetime job security, GS caregivers cannot be lightly dismissed. Indeed, fieldwork interviewees who managed such employees told us repeatedly that it was nearly impossible to dismiss them. Usually, when GS employees had not performed well, one comptroller told us they are simply "bumped down," where they displace a lower-level person while retaining their salary level for two years as they look for another position.

On one installation that we visited, two CDC caregivers had been accused of child maltreatment some four months earlier. Had they been NAF employees, they would have been fired as soon as the allegations were made, our respondent told us.[1] But because they were GS employees, the CDC could not fire them until they went through the normal civilian grievance procedure. This was clearly not a speedy process. In the meantime, the civilian personnel office was "protecting them while the CDC paid their salaries," according to our interviewee. They were not, of course, caring for children; more funds were being expended to support their replacements.

But the advantages do not entirely redound to the employee. GS employees presumably represent a higher-morale workforce that is more likely to stay around, which reduces both search and training costs. In addition, funds going to GS staff salaries contribute to meeting the required APF match. Thus, GS employees reduce the need for NAF from sources other than parent fees. Once service higher-ups understood that GS positions were crucial in reducing MWR burden, they got the word out to commanders, and GS hiring efforts increased.

[1]This is not necessarily true. However, greater employer discretion in the NAF system contributes to such perceptions.

NAF-TO-GS CONVERSIONS

Despite advantages to both the employee and the employer, creating a GS workforce is not without difficulties. Many of the new competitive service positions specified in the act were to be conversions of jobs from NAF to GS. The need to convert NAF positions to GS positions has caused immense difficulties. Indeed, a number of fieldwork interviewees described NAF-to-GS conversions as one of the hardest parts of MCCA implementation. A set of early disincentives to do so (in the form of reimbursement authorization of NAF with APF$) further decreased the impetus to make the effort to convert NAF to GS positions.

Problems in hiring GS employees and converting NAF ones have taken two forms. The first concerns the process of converting NAF employees to competitive service positions. One command representative described the conversion process as "playing Monopoly with Chinese Checkers pieces." Although a major challenge, as discussed in detail below, these problems are essentially temporary. One factor that speeded the process was that APF to NAF reimbursement authorization expired in October 1991, eliminating an important disincentive to convert NAF staff to GS positions. Once all targeted positions are converted, the many problems associated with making the conversions should end.[2]

The second set of problems concerns what it takes to live in a competitive service environment. This is a major and *ongoing* challenge for child development managers. As discussed below, the hiring and employment of GS employees is far more labor-intensive and simply takes much longer. In addition, the flexibility that allowed managers to send employees home with little or no notice when censuses dropped is not available for GS employees. Managing a far more stable staff takes more skill and planning than was the case when everyone or nearly everyone was a NAF employee.

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[2]The Defense Science Board Task Force on Quality of Life (1995) recommends that Congress reinstate the practice of reimbursing child care programs with appropriated funds. Both the House and Senate had approved language lifting this restriction at the time of the report's publication.

Hiring into GS positions and conversion of both positions and their incumbents has been a difficult process in every service. Guidance from the Civilian Personnel Office on how it was to be accomplished came late in the process. At first, a major problem was the lack of APF$ for these positions, even though child care positions were exempt from the first DoD hiring freeze. After the second hiring freeze, from which child care positions were not exempted, the DoD gave the services additional hiring allocations to allow them to continue to fill child care positions. In addition, the DoD has worked with the Office of Personnel Management (OPM) to obtain direct hire and examining authority for caregiver positions.

As noted above, the hallmark of MCCA implementation was its rapid timetable and lack of appropriation. Consequently, money became the major implementation issue in three of the four services, at least at the beginning. Funds came on-line over time, and at different rates in the different services, at the beginning, but requirements for major financial commitments seemed and were overwhelming. Given the POM process, many of these positions would not be included in the POM for two years. To widely varying degrees, the services, major commands, and installation COs made funds available.

But even when money was provided, it did not always wind up where it was intended to go. Typical was the tale of a Navy MWR director, who claimed never to have received over $100,000 that was allocated for NAF-to-GS conversions. When he complained up the chain, nothing happened. However, when he went over his superiors and complained to staff at headquarters, the money came in along with a weekly reporting requirement. This, however, did not occur until the end of FY90 (September 1991), when conversions were to have been accomplished by that time.

Even on Army bases, where child care funding had been more generous than in the other services before the MCCA, funds for GS positions were sometimes slow in arriving. On one Army base that we visited, no APF$ were made available for GS positions until the very end of the first implementation year, when funds were received from the MACOM.

But even after APF$ had begun to be dedicated to this effort, difficulties continued. Some arose from antipathy. Most command respondents agreed with an MWR director, who said "GS staffing gives you less for your money." In some cases, this antipathy translated into inaction. In a message dated June 18, 1992, Marine Corps commanders were exhorted to fill appropriated funded CDP competitive service billets. This message notes that "as of 31 Mar 92, less than half of our installations had fully executed their increase in billets, and nearly a third of the new billets provided Marine Corps-wide were unfilled."

Lack of funds was far from the only impediment to timely NAF-to-GS conversions. No one was ready at the outset with a simple translation between NAF and GS. Different ways of figuring appropriate GS levels were tried over time and services, but it seemed that each approach left someone feeling unappreciated. The bottom line almost everywhere was that employees who had worked together and grown accustomed to whatever status differentials existed among them were unhappy and uncomfortable where their relative statuses changed under the new GS system, which rewarded education, training, and years on the job differently than under NAF. Although NAF employees are eligible for performance awards, GS employees cannot receive them but can look forward to automatic raises based on time in service. The greater security and benefits of GS positions have caused staff to regard GS positions as rewards, according to a high-level Pentagon respondent. Those who do not get them feel disfavored and rejected.

For the most part, fieldwork interviewees reported that decisions about the appropriate mix of APF and NAF staff were made with little or no guidance because guidance had been slow in coming and was often unclear when it did arrive. In particular, interviewees at the major commands and on installations reported that they had not been given clear policy guidance with regard to the optimal percentage of APF staff to be included in CDC staffs. A high-level Marine Corps interviewee said that the lack of specificity was unusual—the regulations allowed locals to decide what positions would

be GS positions and the level of those positions.[3] One respondent noted that in the absence of such guidance, her staff had concluded that one out of every eight caregivers should be a GS employee.

The lack of guidance reflected a key reality of the MCCA: its very rapid implementation timetable. This meant that implementation had to begin before there was time for clear, comprehensive guidelines. To do so, guidance was provided in the form of messages. Messages have the advantage of speed, but because they are brief by their nature, they tend to cover only a highly constrained issue. Hence, there are many messages. Guidance in the form of messages is bound to be fragmented and sometimes contradictory. This was certainly true in the early days of the MCCA.

The lack of clear guidance allowed managers to work within an incentive structure that, at the beginning of implementation, *strongly* favored NAF staffing. By hiring NAF staff, one took advantage of a looser system that made hiring and firing easier and reduced labor costs; reimbursement of NAF with the growing amount of APF$ meant that the net cost to NAF was low. At the same time, use of APF$ for staffing met the match requirements of the MCCA. Finally, the difficult, time-consuming NAF-to-GS conversion process could be avoided.

THE END OF NAF REIMBURSEMENT

But reimbursement of NAF with APF$ did not further the MCCA's goal of 3,700 competitive service positions by September 30, 1991. Moreover, problems elsewhere in the system, well beyond CDP, had led Congress to issue a directive on July 7, 1988, that as of September 30, 1991, such reimbursement would no longer be permitted (U.S. Government, 1988).

The effect of this new rule had a major effect on the implementation of conversions and GS hiring, since it shook up the status quo and

[3]In fact, the DoD did issue guidance in 1990 indicating that the GS/NAF ratio needed to be greater than the 1:8 ratio established in a DoD memorandum dated 26 January 1989, before the passage of the MCCA. The memorandum from the Assistant Secretary of Defense, dated 21 April 1990, notes that the earlier 1:8 limit hinders successful execution of the funds authorized by the MCCA.

staunched the funding stream that had maintained it. The enormous advantages of reimbursement were lost; administrative burdens on both sides increased substantially.

On the NAF side, lack of reimbursement meant that any MWR funds expended for the costs of NAF positions represented a subsidy to child development. It was no longer possible to spend the less constrained MWR money on salaries and be reimbursed later with APF$. This meant that MWR funds spent on CDC employees were not a loan, but a gift. Consequently, willingness to use these funds declined and the expectation increased that APF$ should cover salaries. On the APF side, funds could be used for only limited numbers of things *besides* caregiver salaries; if positions were not converted by the deadline, funds that should be going to fund caregivers might go unspent.

As one command respondent said, the new no-reimbursement rule "stuck a wrench in the wheel of progress." This new policy dramatically changed the cost/benefit calculation for the hiring of NAF versus APF staff. Although our survey data, described below, indicate that the problems associated with hiring APF staff did not go away, a major reason for not hiring them would end with the deadline: easy and rapid NAF hires would ultimately be paid for by APF$. Now, to get the benefits of APF$, one had to hire and employ GS staff. Said a high-level DoD respondent, "no reimbursement forces people to put permanent positions in."

Moving staff from NAF to APF positions was made more difficult because of differing job requirements and rewards for education and previous experience in the two systems. One manager told us that a person with a particular set of credentials coming in off the street might qualify for a GS-5 position, whereas someone who had been a NAF caregiver for 20 years might get a GS-4. The many changes caused a great deal of confusion. We were told by one CDP manager, for example, that a GS-5 position did not require an associate degree; this made it difficult for her to credibly encourage NAF staff to get additional training and CDA credentials.

Hiring into GS positions from outside was also difficult since the competitive service system did not have an appropriate category for

CDC caregivers.[4] One Marine Corps comptroller told us that, since GS-4 is typically a secretary's position, he asked OPM to set aside a separate category for caregivers, but he was not successful. A colleague in the Air Force concurred. He noted that GS system job requirements tend to select employees who may not be interested in kids. "When we lose lead teachers, we should be able to go into the community. But the tendency with APF is to get people who don't want to work with children but who do have the requirements for the grade. It becomes a swinging door for people who want to move on to higher positions." Another manager echoed these problems. She had trouble recruiting for caregiver positions because applications for such positions went into a clerical pool. What she needed, she said, was a special caregiver category.[5] This would eliminate the need to deal with people who were looking for clerical jobs. However, in the huge competitive service bureaucracy, creation of a new job category was an overwhelming task.

Some of the hiring and conversion problems that child development managers experienced came because of the effect of MCCA requirements on management of the civilian DoD workforce. For example, rules about progression may limit who may be hired and promoted. One T&C spec told us that some of the older caregivers, who would have made "good GS-2s," were not allowed to stay GS-2s, but were required to advance to GS-4 or GS-5 jobs. This limited her options as a manager: Some of these people, who had been grandfathered in, had to be terminated after failing to complete training requirements for the higher-level positions some did not even want.

A ZERO-SUM GAME

The MCCA set a floor for GS positions for child development, as discussed above. However, this substantial increase was not mirrored in an overall increase in the floor for all GS positions. The DoD

[4]The Services Non-Appropriated Fund Civilian Personnel Office (CPO) system created a specific occupational series for CDS caregivers with specific training and education requirements in 1990.

[5]The Army continues to experience problems with reduction in force (RIF) candidates who do not wish to work with children being placed into caregiving positions.

has a fixed number of authorizations (full-time equivalents—FTEs) for civilian positions that are given to the services. By raising the floor for child care positions but not raising it overall, GS caregiver positions would have to come out of the pool of civilian positions.

This created a zero-sum game and the animosity that accompanies same: If a civilian is hired to work in child care, this reduces the number of positions available for other civilian workers. In addition, the cap results in situations where there may be enough money in the budget to hire additional civilians, but the authorization to do so may be lacking.[6] This cap caused civilian workforce managers to view the heavy hiring and conversion by child development managers with concern and alarm in many places. Downsizing has exacerbated this problem. Commanding officers and comptrollers told us they resented that increasingly scarce civilian jobs were going to the CDCs.

The need to get hiring authorizations meant that many authorized billets were unfilled. For example, at an Army installation, the CDC had 51 billets at the time of our visit but was authorized for only 35 positions. A high-level Army respondent told us that this problem was true Army-wide. "We have enough APF$," she said, "but we can't use it on people." A similar problem was described by an Air Force respondent. There, one needs a hiring credit to hire a GS worker, even when funds are available. Getting hiring credits is not easy, although our respondent, an MWR director, had been informed just the day before our mid-March 1993 interview that they had been granted hiring credits for 11 funded CDC positions for the fiscal year.

The inability to hire left many managers with a *lot* of money. A particularly feisty manager at one installation we visited was angry about this and determined to cope. "I won't turn back *one dollar* [of APF money]," she said, "so it is a grand time to experiment." Indeed, many managers faced with the same problem had arrived at the same conclusion, although generally more quietly. Many were laying in large stores of supplies and equipment, rather than return money for staff whom they could not hire.

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[6]This problem led the Defense Science Board Task Force on Quality of Life (1995) to recommend that full-time equivalency limits for child care programs be lifted.

Survey data support the view that the end of the ability to reimburse NAF$ with APF$ was a major problem for child development. As shown in Table 8.2, most (55 percent) respondents described the inability to reimburse NAF with APF$ as a significant or enormous problem at the time of the survey. Marine Corps respondents were most likely to describe inability to reimburse as a major problem; Air Force respondents had the fewest problems.

Table 8.2

Difficulty Associated with Inability to Reimburse NAF$ with APF$, by Service

Service	Mean Difficulty Rating	No.
Air Force	2.3	62
Army	2.7	55
Marine Corps	3.4	11
Navy	2.5	53
Mean	2.6[a]	181

SOURCE: Data from mail survey.

NOTE: Cell entry is based on scale with 1 = no problem, 2 = small problem, 3 = significant problem, 4 = enormous problem.

[a]Means are significantly different across services: $p < 0.01$ (F-test).

HIRING DELAYS

Despite the reimbursement rule change, many positions were not converted by the September 30, 1991, deadline. Our survey data indicate that the process was far from complete some time after the deadline had passed, although overall, the DoD met the deadline.[7] The many disincentives to convert, combined with a system that made the process extremely complicated, continued to undermine implementation of this MCCA requirement.

Some of our fieldwork interviewees attributed the delay in hiring to a DoD hiring freeze which was extended to child care in March 1991

[7]A higher than required number of conversions in the Navy compensated for a shortfall in the Air Force.

(Department of the Navy memo dated June 14, 1991). But others argued that this in fact was not the problem. Documents from all the services suggest that the problem may have been a more fundamental and enduring one: difficulties in negotiating NAF to APF conversions across MWR. The title of a memo from the Bureau of Naval Personnel to all MWR directors dated 13 August 1991 tells the tale: Conversion of NAF Positions/Employees to the Federal Service—The Continuing Saga. Attached to this memo is a booklet developed by the NAF personnel office entitled, *The Conversion Maze: A NAF Manager's Guide.* The cover depicts a traditional English maze, with a dollar sign at the center.

Delays and problems appeared throughout the system. One comptroller to whom we spoke focused the problem on MWR. No one in MWR had done a NAF-APF conversion in 20 years, he noted. "It took forever for MWR to get position descriptions written." There was, he continued, "no good team to make it all happen." Interviewees everywhere concurred. One high-level Pentagon respondent told us that her own position had taken more than a year to convert.

Nearly all survey respondents indicated that it took more than a month to fill a CDC caregiver position, and more than one-third (37 percent) indicated that it took four months or more.[8] We found that the average number of months to fill a GS position as reported by our survey respondents was 3.09 months; the cross-service mean for NAF positions was much shorter: 1.11 months. As shown in Table 8.3, differences by service within each employment category were significant at the 0.02 level (F-test). More important, differences between NAF and GS hiring times were highly significant.

One reason that it often takes so long to hire into caregiver (GS and NAF) positions is the need to run a series of background checks on new hires, although only the local installation check must be completed before hiring may occur.[9]

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[8]To get a better sense of the average time to fill a GS position, we converted the categorical responses on the survey to months by replacing each response category by the midpoint of the interval (so the category 4–6 months was replaced by the number 5). For the last category, more than 6 months, we used the most conservative assumption: that each respondent meant 6 months.

[9]Some of these checks are required by the Crime Control Act, P.L. 101-647, November 29, 1990, section 231. Many respondents confused the requirements of the Crime

As shown in Table 8.4, respondents across the services reported that background checks were quite time-consuming; there were no significant differences by service, in part because of substantial variance in reported times for the checks, particularly in the Army. Comparisons of the time required for each kind of check were made using pairwise t-tests. These analyses indicate that FBI fingerprint checks take significantly longer than all other forms, except the national agency check, which takes significantly longer than the FBI check.

How much of a burden do these background checks impose overall? We have already seen that they are time-consuming. Seventy-three percent of respondents indicated that they experienced delays in completing checks; differences across services were not significant. Table 8.5 presents the number of checks our respondents reported having run. It also indicates the percentage of checks that came back with negative comments.

Table 8.5 reveals no significant differences across services in the mean number of checks performed or in the percentage of checks returned with derogatory comments. However, looking across

Table 8.3

Average Time in Months to Fill NAF and GS Caregiver Positions, by Service

Service	NAF	GS	No.
Air Force	0.84	2.68	85
Army	1.51	3.11	64
Marine Corps	0.96	2.85	13
Navy	1.08	3.63	68
Total	1.11[a]	3.09	230

SOURCE: Data from mail survey.

[a]Means across services within each caregiver category are significantly different: $p < 0.02$ (F-test). Differences in mean times across GS and NAF categories are highly significant: $p < 0.0000$ (F-test).

Control Act with those of the MCCA, and heaped additional scorn on the MCCA for complicating the hiring process in this way.

Table 8.4

Average Time in Months to Complete Background Checks for GS Positions, by Service

Service	FBI Fingerprint	National Agency	State Background (Crime Control Act)	Local Installation	Service Central Child Abuse Registry
Air Force	6.5	8.4	2.8	1.2	2.3
Army	4.9[a]	5.6	3.6	2.5	2.5
Marine Corps	4.3	5.2	3.1	1.7	2.2
Navy	5.7	6.9	1.6	2.2	3.2
Total	5.7	7.0	2.7	1.9	2.8

SOURCE: Data from mail survey.

[a]Responses of over 20 months were recoded to 20 months; responses of 0 were recoded to 0.5 months, the midpoint of the interval. Such recoding was required for only a few respondents.

Table 8.5

Number of Checks Done and Percentage Returned with Negative Comments, by Service

	FBI Fingerprint		National Agency		State Background		Local Installation		Service Central Child Abuse Registry	
Service	Mean No. Done	% Negative	Mean No. Done	% Negative	Mean No. Done	% Negative	Mean No. Done	% Negative	Mean No. Done	% Negative
Air Force	44.7	0.40	41.9	0.91	44.7	0.87	43.6	1.4	24.6	0.19
Army	39.0	0.87	32.3	2.5	26.6	1.2	40.6	10.1	46.3	2.1
Marine Corps	41.2	0.28	54.3	0.78	30.4	0.0	54.8	0.84	30.2	0.0
Navy	42.4	0.38	43.8	6.5	33.3	0.38	47.8	16.7	42.1	12.4
Total	42.7	0.46	42.5	2.9	37.9	0.76	45.1	8.1	39.2	6.5

SOURCE: Data from mail survey.

checks, percentages returned with derogatory comments vary considerably by type of check. FBI fingerprint checks yield the lowest percentage of derogatory checks, an interesting finding given that fingerprint checks are one of the slowest to complete, and the only one required to come back before a person may begin work.

Service central child abuse registry checks reveal the highest "hit" rate.

As noted below, most (73 percent) respondents indicated that they had experienced delays in completing required background checks. Table 8.6 presents the percentage of respondents who described each potential problem as a problem for them.

Aside from hiring and conversion difficulties, the hiring and conversion of some staff into GS caregiver positions created morale problems in CDCs. Different salary and benefit levels create a division within the caregiving staff, according to a CDC caregiver at a Naval base we visited. The two systems handle raises and incentives differently as well.

Our survey data allowed us to look at GS employment at a point when funding of GS positions was by and large no longer an issue, as funds for child development had had time to find their way into the budget. However, many of the problems associated with conversions and hiring endured.

Looking back over time, we find that the additional GS positions authorized in the MCCA addressed a situation of some inequality across the services that existed before the MCCA. As shown in Table 8.7, the average number of GS positions per CDC varied dramatically by service before the implementation of the MCCA.

Table 8.6

Percentage Noting Background Check Problems, by Service

Service	Bad Fingerprints	Lost or Incomplete Records	Logistics (Time, Lost Records)	Differing State Requirements	Funding of Checks
Air Force	28.4	11.7	37.5	15.9	9.1
Army	42.8	8.6	35.7	7.1	5.7
Marine Corps	7.7	7.7	53.8	23.1	0.0
Navy	35.6	19.2	42.5	0.0	0.0
Total	33.6[a]	12.7	39.3	9.0	4.9[a]

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.05$ (F-test).

Table 8.7

Mean Number of GS Positions per CDC Pre-MCCA, by Service

Service	Mean GS Positions per CDC	No.
Air Force	1.3	79
Army	5.0	63
Marine Corps	1.0	13
Navy	0.9	70
Mean	2.2[a]	225

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.0000$ (F-test).

The MCCA increased the number of GS positions per CDC dramatically. As shown in column 1 of Table 8.8, the average number of new GS positions was substantial and did not vary by service. However, because of substantial pre-MCCA differences in numbers of GS positions per CDC, the mean number of such positions per CDC

Table 8.8

Mean Number of New and Total GS Positions per CDC Post-MCCA, by Service

Service	Mean New Positions Post-MCCA	Total Number per CDC	Percent NAF Conversions	No.
Air Force	7.5	9.0	49	83
Army	10.0	15.3	71	66
Marine Corps	10.2	11.2	71	13
Navy	9.1	10.2	91	73
Mean	8.9	11.3[a]	69[b]	225

SOURCE: Data from mail survey.

[a]Cross-services differences in column 2 are significantly different: $p < 0.0000$ (F-test). The figures in column 2, which represent the sum of the numbers in column 1 and those in Table 8.3, may not sum exactly because of rounding errors.

[b]The percentages in column 3 are significantly different: $p < 0.0000$ (F-test).

continued to be significantly different across services at the time of our survey, as shown in column 2 of Table 8.7.

Not surprisingly, most of the new GS positions that survey respondents reported were NAF conversions. As shown in column 3 of Table 8.8, more than two-thirds of GS positions were conversions from NAF. In the Navy, nearly all GS positions were conversions; the comparable figure in the Air Force was just under one-half.

CONCLUSIONS

Given the many problems associated with GS conversions and hires, it is noteworthy that by December 1991, all services except the Marine Corps had reached their GS hiring and conversion goals. There is a sense in our data that people now understand the need for GS positions and have largely resolved the staff morale problems associated with early GS hires and conversions.

Realignment of the caregiver workforce was one of the most difficult aspects of MCCA implementation. Unlike other aspects of the implementation effort, this provision depended on offices that had little experience in doing the work, and was forced to work against powerful implementation disincentives, most particularly the ability to reimburse NAF$ with APF$.

Given rapid implementation timetables, the field was forced to move at first in the absence of critical guidance about the percentage of employees who should be GS, how to convert employees from NAF to GS, and how to find applicants who wanted GS *caregiver* work.

Over time, as guidance became available and the Civilian Personnel Office became more experienced with conversions, implementation became easier and therefore was more likely to occur. The impending deadline on the ability to reimburse NAF$ with APF$ energized the conversion process.

An argument could be made at this point that reinstatement of reimbursement authority is justified at least in CDP, particularly if monitoring of hires is in place. This authority would increase flexibility and allow CDP managers to use limited resources far more efficiently.

Chapter Nine

PARENT PARTNERSHIPS

Along with its many other provisions, Congress set out through the MCCA to increase the involvement of parents in CDCs. The MCCA indicated in Section 1506, subsection (a) that:

> The Secretary of Defense shall require that there be established at each military child development center a board of parents, to be composed of parents of children attending the center. The board shall meet periodically with staff of the center and the commander of the installation served by the center for the purpose of discussing problems and concerns. The board, together with the staff of the center, shall be responsible for coordinating the parent participation program....

This parent participation program is described in the next section of the legislation.

The law directs the Secretary of Defense to require a parent participation program at each CDC and permitted the Secretary of Defense to charge participating parents a lower fee for child care.

Clearly, the Congress was serious about increasing the level of parent involvement in the CDCs. But the type of involvement that parents were to have was not entirely clear.

From the beginning, many of those responsible for the implementation of the MCCA consigned the parent involvement component to a lower tier in terms of urgency of implementation. Many described this aspect of the MCCA as second priority, something that they would try to get to as soon as the major components, which included

fees, training, and hiring and GS conversions, were under control. Lacking deadlines or fiscal implications, it was relatively easy to make this choice. At the same time, the fact that this provision of the MCCA could be accomplished without extra funds and, for the most part, by simply decreeing the existence of such a board made at least pro forma implementation widespread.

PARENT BOARD PROLIFERATION

Indeed, at the time of our survey, we found that parent boards in CDCs were nearly ubiquitous. As shown in Table 9.1, virtually all respondents indicated that there was a CDC parent board on their installation. Differences across services in percentage of CDCs with a parent board were nevertheless significant, with the percentage of boards lowest in the Army.

Our survey data indicate that the MCCA parent board requirement was a significant factor in the establishment of these boards. As shown in Table 9.2, the vast majority of the boards on the installations included in our survey sample had been established after the passage of the MCCA. Notable exceptions were the Marine Corps and the Army.

Our data suggest that even when a parent board existed before the MCCA, there was a moderate chance that it would change in some way in response to MCCA requirements. As shown in Table 9.3,

Table 9.1

Percentage of Respondents Who Indicated Presence of Parent Board, by Service

Service	Percentage	No.
Air Force	99	88
Army	90	69
Marine Corps	100	13
Navy	99	73
Mean	96[a]	243

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.01$ (F-test).

Table 9.2

Percentage of Respondents Who Indicated That Parent Board Was Established After January 1990, by Service

Service	Percentage	No.
Air Force	78	85
Army	51	59
Marine Corps	42	12
Navy	76	67
Mean	68[a]	223

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

Table 9.3

Percentage of Respondents Who Indicated That a Preexisting Parent Board Had Changed in Response to the MCCA, by Service

Service	Percentage	No.
Air Force	58	19
Army	43	30
Marine Corps	75	8
Navy	17	18
Mean	44[a]	75

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.02$ (F-test).

almost half of those respondents who indicated that their installation had had a parent board before the passage of the MCCA indicated that the board had changed in some way in response to the legislation.

Although the intent of Congress was not entirely clear in requiring parent involvement, one goal of such boards often is to bring new parent stakeholders into management decisions and hence alter the way that CDCs operate. For this reason, we asked survey respondents if the parent board had brought about any changes in the management or operations of the CDC(s). As shown in Table 9.4,

Table 9.4

Percentage of Respondents Who Indicated That the Parent Board Has Brought Changes in CDC Management or Operations, by Service

Service	Percentage	No.
Air Force	39	77
Army	54	57
Marine Corps	33	12
Navy	38	69
Mean	42[a]	215

SOURCE: Data from mail survey.

[a]Means are not significantly different (F-test).

a substantial minority of respondents indicated that, indeed, the board had brought about such changes. The highest percentage was found among Army respondents, suggesting here again that a tradition of parent involvement translated into parent effects.

PARENT BOARD INFLUENCE

To some extent, the findings concerning parent boards from our fieldwork paint a somewhat different picture than those from the survey. In particular, we found during fieldwork that the parent boards, which did indeed seem to be ubiquitous, were almost universally described as having little or no power in terms of CDC operations. Although their establishment and presence may indeed have changed CDC management and operations, the changes were few and at the margins for the most part. Indeed, one high-level Army respondent believed that parent boards had had no effect whatsoever.

We asked fieldwork interviewees to tell us about the parent boards and what influence they had had on the CDC. For the most part, they described boards that received, rather than provided, information. Fieldwork interviewees indicated that parent boards tended to be most active in organizing parent participation, which is their assigned task in the MCCA. We did not hear of instances in which boards had questioned important policy decisions or sought to make them themselves. Indeed, those parents whom we interviewed who

were involved on boards were clear that they did not see themselves in policymaking roles.

Despite our survey findings of a substantial increase in parent board penetration in response to the MCCA, a number of higher-ranked military and civilian interviewees told us that parent boards were one MCCA provision that they had essentially tabled in the interest of moving the more difficult and central aspects of the MCCA forward. Thus, despite their widespread existence, there had been few regulations or communications from higher-ups concerning what the boards ought to be doing or how their effectiveness might be assessed. A high-level Marine Corps interviewee regretted the lack of headquarters involvement in this aspect of the MCCA.

The structure and dispersal of parent boards varied substantially across installations. There were usually just one or two boards, each assigned to one CDC, but we visited a large installation that had a central advisory board as well as a board for each CDC. In some locations, there were separate boards in each CDC for the part-day and full-day programs. When this occurred, the part-day board was invariably more involved and its voice was far more likely to be heard in the establishment of CDC policy. Most respondents who addressed this issue believed that dividing parent boards between the part-day and full-day programs was a mistake. Parents with children in part-day programs were invariably more involved in large part because, in most cases, one parent was not a full-time worker and thus had more time to participate. A few respondents also noted that such parents tended to be from higher-ranked families and thus were more articulate and determined to be heard.

With the exception of boards for part-day programs, for the most part members of parent boards represented a cross section of CDC users. Often, they are given time off from their regular duty assignment to participate on the board. In places where parents did not receive release time for board participation, some CDC directors told us that it was hard to get parents to serve. Meetings, typically held monthly, focus on the organization of fund-raising activities, such as bake sales, or on activities that raised funds while involving families, such as fairs or circuses.

Board interests vary across installations, as reported by CDC staff. One CDC manager told us that if the topic was not fees, which invariably arouses strong feelings among board members, there is little interest. Other managers told us that their boards had been helpful in a variety of ways, e.g., pushing the U.S. Department of Agriculture (USDA) food program, initiating a toy doctor program to repair broken toys, and helping to repair playground structures. In some instances, boards raised issues of concern to parents, such as care for sick children and requests for daily written reports from caregivers.

Most of the few parents to whom we spoke were satisfied with their own level of involvement in the CDC. In many cases, parents told us that their level of involvement was minimal, and that they were happy to trust CDC management to take care of things and deliver a high-quality program. Indeed, a number of parents told us that they had selected a *military* child development center because they believed that they could trust military members and civilian employees of the DoD to take their interests into account. They may have appreciated the communication that came home about curriculum and goals, but this information did not propel them to become involved.

Although parent boards were generally not functioning in a policymaking role, and most nonboard parents were not involved in CDC operations or policymaking, we generally found more reports of parent involvement in accredited centers. The self-study process and subsequent accreditation of the CDC tended to involve parents. Many respondents, both CDC staff members and parents, noted that as a result of that process, parents were now more involved. Caregivers and CDC managers attributed this largely to new skills that caregivers had developed in communicating with parents as well as their greater understanding of the importance of parent involvement in optimal child development. Caregivers often told us that they made more of a point after accreditation to talk with parents and make sure that they were aware of both CDC events and their own child's progress. In some cases, new policies that came into being in the process of accreditation improved such communication. For example, less combining of rooms at the beginning and end of the day increased the likelihood that the parent would encounter at drop-off and/or pick-up the staff member who actually had spent the day with their child. Encountering this person, one respondent told us, encourages parents to ask questions about their child's day.

CONCLUSIONS

The parent boards that Congress mandated in the MCCA were implemented widely. The fact that a parent board could be established essentially by decree increased the likelihood of implementation. The need to focus on the more central and time-consuming aspects of MCCA implementation contributed to a lack of guidelines or directives for these boards in most cases.

Release time from work assignment for some parent participants ensured a high level of involvement in their functioning. When this has not occurred, parent participation has been hard to sustain.

Parent boards have had varying levels of effect on CDCs. Few have influenced CDC policy or operations. Many have become a resource upon which staff can call for repairs, support, and fund raising. This latter area has also contributed to increased parent involvement more generally. Carnivals and fairs, designed to raise funds, have engaged families and caused them to connect to CDCs in new and different ways.

Chapter Ten

FAMILY CHILD CARE SUBSIDIES

The military has long had a tentative and complicated relationship with FCC. Much of the reason stems from the military's wish to avoid the liabilities that are perceived to attach to child care delivered in military quarters by solitary women. Indeed, a child care manager to whom we spoke early in the first phase of RAND's military child care research told us that she had begun to think about FCC as "a center without walls," and was quickly reminded that liability issues precluded such an approach. Just a few weeks later, a command respondent described FCC as a lot like Avon: It was a business run by a military spouse out of her government quarters. This analogy allowed the respondent to justify the very low level of monitoring of the delivery of care at that time on that installation, before the passage of the MCCA. "After all," he said, "we wouldn't tell her [as the Avon lady] what lipstick to sell; how can we tell her how to do child care?" (See Zellman, Johansen, and Meredith, 1992, for further discussion of family child care before the MCCA.)

Over the years since these conversations, the military has been telling military spouses more and more about how to do child care in their homes. The MCCA was a major factor in this process. Although some boundaries remain firmly in place between the military and the child care provided by dependents in military quarters, the MCCA made those boundaries far more porous by including in its provision for a report on five-year demand for child care (Sec. 1507) a subsection (c) that required a report that described "methods for monitoring family home day care programs of the military departments." The inspection program that was promulgated by the DoD also

brought FCC into sharper focus. Now, certification of a program required that FCC also pass muster, as described in more detail below.

Government investment in FCC in the form of training, licensing, and oversight of FCC providers was a policy of long standing. There had even been some subsidization of liability insurance and equipment needs (e.g., toy and equipment loan programs). But the MCCA made the boundary between the military and FCC more porous by permitting direct subsidy of FCC providers as a means of lowering the cost of FCC care to parents. Section 1508 provided for subsidies for family home day care:

> The Secretary of Defense may use appropriated funds available for military child care purposes to provide assistance to family home day care providers so that family home day care services can be provided to members of the Armed Forces at a cost comparable to the cost of services provided by child development centers.

An undated DoD Background Paper provided to commanders at the November 1992 Commander Conference explained the rationale for direct FCC provider subsidies:

- Each child care center space costs the military service $2,500 in appropriated funds (amount required to match parent fees). Each FCC space costs $400, which includes the cost of management oversight, training, and some equipment support.
- Since 1989, fees charged by providers have increased, whereas center fees have been reduced, especially for lower-income families. Parents are unhappy about the higher FCC fees and in some areas, this has increased the demand for center care. There are also indications this has caused a decline in the number of spouses willing to provide FCC.

Despite the economic logic behind FCC subsidization, the FCC subsidy program is one provision of the MCCA that has not been widely implemented; indeed, in fieldwork sites, implementation of any subsidies was not common; direct cash subsidies were particularly rare. Part of the reason, of course, is that, unlike nearly all other MCCA provisions, this one was optional, and the incentives to provide subsidies were not apparent, as discussed below. No doubt, people were so pleased and relieved not to *have* to do something,

they let it pass. Despite the substantial promise that subsidies hold for integrating FCC into a child development system, subsidies have been ignored and, in some cases, actively rejected across the services, with a few notable exceptions.

BENEFITS OF SUBSIDIES

The promise of subsidies is considerable. As discussed in our earlier report (Zellman, Johansen, and Meredith, 1992), the substantial subsidization of each CDC slot and the lack of subsidization of FCC care creates a considerable price disparity in some cases. As long as care in CDCs is subsidized and therefore cheaper, parents will prefer such care over any other form of care available. This price disparity is an important reason for the continuing long waiting lists for CDC care. As we note in our 1992 report, waiting lists for CDC care may include both families who have no other source of care and those who are currently using FCC care but prefer CDC care, at least in part for its lower cost. By subsidizing the cost of FCC care, such care could be provided more cheaply, at rates comparable to those charged at the CDCs, and FCC providers would not be forced to subsidize care themselves by keeping their fees unrealistically low, as some do now. If FCC care cost the same as CDC care, there might remain some preference for CDC care because it is still perceived as safer and more reliable, but the length of waiting lists would likely decrease. And if FCC care were subsidized at a level that made it cheaper than CDC care, waiting lists would further decline.

In addition, subsidies would increase the number of spouses who were willing to provide such care. As discussed below, limited experimentation with subsidies has revealed that relatively small payments can substantially increase the level of supply of FCC care.

LACK OF POLICY SUPPORT

But to a significant degree, the promise of subsidization has not been met. Two reasons stand out. First, people remain worried about FCC, and wish to stay at arm's distance from the liabilities that are widely perceived to inhere in it. Second, there remains a sense that

giving FCC providers cash is not an appropriate use of APF$.[1] Consequently, there has been only limited effort to promote the use of the direct subsidies permitted in the MCCA. Indeed, those few respondents who had become involved in direct subsidies noted that there had been almost no guidance concerning what was allowed or how to do it. The Navy made a policy decision that it was not appropriate to use APF$ for direct subsidies of FCC providers. The Navy has chosen to limit FCC subsidies to indirect support: training, materials, equipment lending, games, and toys. There is also some subsidization of insurance in some locations.[2]

The Navy's decision not to provide direct subsidies conflicted with a Marine Corps decision to provide them. At one base (Quantico), when the CDC was closed after inspection, cash subsidies were authorized to quickly expand FCC so that children displaced from the CDC could be accommodated. However, the direct subsidies were never implemented.

At the service level, the Army has been the only service to promote FCC subsidies in an organized way. Indeed, a high-level Army respondent described his service's response to subsidies as "aggressive."[3] Part of this aggressive response was a specific policy guidance concerning how to do them. Early Army experimentation with FCC subsidies has been fairly widespread. According to Army interviewees, these experiments have found subsidies to increase and target the supply of FCC care. The emphasis has been on infant, hourly, and extended hours care, types of care that are costly to provide in CDCs and largely unavailable in civilian centers. A MACOM respondent told us, for example, that direct FCC subsidies, which had been in place for approximately four months at the time of RAND's interview, had increased infant and toddler spaces by 43 percent. The subsidy there is $150 per month per child. Under the conditions of the subsidy, the provider must agree to take only infants and toddlers, which limits the number of children to three, and

[1]This represents a more general aversion to subsidization of private contractors in some quarters.

[2]This decision has been reversed since our data collection activities.

[3]Beginning in FY95, the Army authorized installation CDS programs to use a portion of the new funds that the Army received to increase slots for FCC subsidies. As a result, most installations now have a subsidy program.

hence the subsidy cannot exceed $450 per month. There has also been some experimentation with providing FCC providers with a paid vacation—something unheard of for Avon ladies! Isolated efforts in other services suggested that there, too, subsidies were effective in increasing the supply of FCC care.

For the most part, the other services had done little about subsidies. Typical was the response of one Marine Corps FCC coordinator. Although the FCC program had expanded and improved, largely because the MCCA had provided for a full-time coordinator position, she felt that the program had not begun to meet its promise. In particular, she noted that she had heard about the opportunity to provide cash subsidies to FCC providers, but no information or guidance had come down about how to do this. Consequently, nothing had happened on her installation.

LIMITED USE

Despite evidence that subsidies increase the supply and attractiveness of FCC care, there remains reluctance to pay providers directly. As shown in Table 10.1, cash subsidies were rare at the time of our survey in 1993, except in the Army, where nearly half of respondents reported that there have been cash subsidies paid to at least some FCC providers.

Table 10.1 underscores the importance of the Army's affirmative effort to promote the use of subsidies: Army respondents were far

Table 10.1

Percentage of Respondents Reporting Cash Subsidies, by Service

Service	Percentage	No.
Air Force	4	82
Army	46	59
Marine Corps	8	12
Navy	4	55
Mean	16[a]	208

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

more likely to report the use of cash subsidies than respondents in the other services.

Interviewees on several Army bases told us that subsidies targeted to providers of infant care helped to increase the supply of such care. Subsidies of $5 per day per child to infant care providers in one location had been effective in opening up more infant slots—from 12 before subsidization to more than 40 at the time of our visit.

On another Army installation we visited, the apparent impetus for subsidies came from parental complaints about the inequities in cost between CDC and FCC infant care. The FCC coordinator was looking into the possibility of subsidies to FCC infant providers as a means of equalizing the costs between the CDC and FCC. But in some cases, the military's incentive to provide direct subsidies to FCC providers is lacking. Besides reluctance to spend money and become more closely involved in the FCC program, the reality is that some FCC providers have accepted the need for self-subsidization. An Army child development manager to whom we spoke told us that providers on her installation had long provided their own subsidies by lowering their charges to parents to compete with the subsidized slots in the CDC.

In sharp contrast, indirect subsidies—payment in the form of insurance, toy lending, and playground equipment for the housing area—are common. On one Army base that we visited, there were no direct subsidies, but the provision of expendable business and child care supplies and free insurance coverage resulted in a yearly subsidy that the CDP director figured was worth as much as $1,000 per year per provider.

RAND argues in its 1992 report and in a recent paper in *Armed Forces & Society* (Zellman and Johansen, 1995) that military child care needs to function in a more systemic way. Key to making child care a system is bringing FCC into the child care mainstream by equalizing training and other aspects of quality, assigning hourly care to FCC, and helping parents to use those aspects of the system that best meet their own and the military's needs. More guidance and encouragement concerning the use of subsidies would help to make this possible. In our view, direct subsidies to FCC can help to achieve these goals by increasing the overall size of FCC, and by encouraging sup-

port for those types of child care that managers and researchers have determined are better provided in FCC than in CDCs. In particular, we urge the subsidization of care for infants, who are better served in FCC than in CDCs.

CONCLUSIONS

Given the press of time, inadequate funds in the early years, and a large number of MCCA provisions that would be aggressively monitored, it is hardly surprising that FCC subsidies received little attention. As one of the few discretionary provisions of the MCCA, direct subsidies were often ignored in the rush to implement major MCCA provisions.

In some cases, such subsidies were prohibited as a matter of policy. Policymakers were clearly uncomfortable giving individual civilian dependents taxpayer money to provide a service or support their business.

But in fact, the system and the consumer as well as the FCC provider benefit from direct subsidies. For the system, a viable network of FCC providers gives parents more choices and permits a better match between family needs and provider capability than is often the case in CDCs. Subsidies also decrease the disparity between lower CDC fees and higher FCC ones. Such disparities increase the length of waiting lists by causing parents who are using FCC care to seek a CDC slot as a means, in part, of reducing child care costs. We urge strong policies promoting FCC subsidization in every service.

Chapter Eleven

ACCREDITATION

Section 1509 of the MCCA contained a provision that required at least 50 military CDCs to be accredited in accordance with the standards of a national accrediting body for early childhood programs.[1] Accreditation of these 50 centers was to be completed by June 1, 1991. The 50 accredited CDCs were to serve as a "demonstration program" from which other nonaccredited centers could learn about best practice. An independent organization was to evaluate the effects of CDC accreditation, including the effect on child outcomes. The evaluation would address the desirability of mandating that all military CDCs be accredited.

A more limited evaluation of the effects of accreditation than was envisioned by Congress was undertaken as a separate but integral part of this study.[2] The results of the evaluation study are reported in detail in Zellman, Johansen, and Van Winkle (1994). This chapter draws heavily on that report and will describe accreditation requirements, the accreditation process, and the effects of accreditation. The chapter concludes with a discussion of the desirability of a universal accreditation requirement.

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[1]The National Academy of Early Childhood Programs, a division of the National Association for the Education of Young Children, offers the only set of standards for early childhood programs that leads to national accreditation (Hayes, Palmer, and Zaslow, 1990). We use NAEYC throughout the text to refer to both NAEYC and NAECP because the former term is more widely known.

[2]Because of funding constraints and the inability to randomly assign to the accreditation or comparison condition, a more modest evaluation that did not include measures of child outcomes was undertaken. See Zellman, Johansen, and Van Winkle (1994) for more discussion of design modifications.

ACCREDITATION REQUIREMENTS

NAEYC has established a set of professional quality standards that must be met for a child development center to become accredited. These standards were developed on the basis of a comprehensive review of the available literature regarding child development and child care quality, and on the basis of the judgment of 175 early childhood specialists (Hayes, Palmer, and Zaslow, 1990).

NAEYC's standards incorporate two types of indicators: structural elements, such as group size, caregiver-to-child ratio, caregiver training, available space, and equipment (e.g., Berk, 1985; Fosburg, 1981; Ruopp et al., 1979), and indicators of children's daily experiences in care, such as how caregiver and child interact (e.g., Anderson et al., 1981; Carew, 1980; Rosenblith, 1992). Of the two indicator categories, the latter is more closely linked to developmental outcomes (Belsky, 1984; Bredekamp, 1986), with caregiver-child interactions particularly closely associated with child development outcomes such as gains in cognitive development (Hayes, Palmer, and Zaslow, 1990).[3] Indeed, indicators in the first category, structural aspects of care, are considered to be important because their presence supports and facilitates more optimal interactions (Belsky, 1984; Ruopp et al., 1979).

In addition to specifying standards of care, NAEYC also specifies goals for quality care, which serve to guide the provision of child care. For example, although NAEYC specifies preferred caregiver-to-child ratios and group sizes by age, it makes clear that the goal of these ratios is to provide children with quality care by known providers. Consequently, frequent shuffling of children throughout the day and use of part-time staff as a means of maintaining ratios is inimical to the overall goal of high-quality care.[4] The specification of both standards and goals prevents the erosion of care in the service of maintenance of standards.

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[3]Hayes, Palmer, and Zaslow (1990) note, for example, that in the comprehensive study of Bermudian child care centers, caregiver speech to children was the strongest predictor of developmental progress (McCartney et al., 1982).

[4]This latter point is of particular relevance to military CDCs, as military requirements for group sizes and child-to-caregiver ratios are at the high end of, and sometimes exceed, recommended NAEYC standards, as described below.

Achieving accreditation requires completion of a three-step process that includes (1) a self-study, (2) a site validation, and (3) a commission decision (NAEYC, 1991). In the military setting, the accreditation process begins by gaining approval from the installation commander (or other higher-level authority) and applying to the National Academy of Early Childhood Programs, a division of NAEYC. Once the initial application is processed, the academy provides the materials for centers to conduct a self-study. During the self-study process, CDC managers, staff, and parents work together to measure their caregiving practices against the criteria established by NAEYC.

An important aspect of the self-study is the active involvement of center personnel in the evaluation of child care delivery. Indeed, the first of two major NAEYC goals for accreditation is "to help early childhood program staff become involved in a process that will facilitate improvements in quality . . . ." (NAEYC, 1991, p. 1). NAEYC materials emphasize that progress through the accreditation process depends critically on the cooperation and participation of center staff. When the self-study is completed and the decision to proceed to a validation visit has been made, the results of the self-study are collected and reported to the academy. Information is presented as a program description, which has a standard format, organization, and length.

The purpose of the validation visit is to verify that the written program description submitted by the CDC staff accurately reflects the daily operations of the center.[5] Validators meet with the center director, tour the facility, observe a sample of classrooms, interview caregivers in these classrooms, review records and written policies, and conduct an in-depth discussion with the director about the validation process. Validators do not make the actual accreditation decision but report their findings on the accuracy of the program description to the academy. A three-person accreditation commission, consisting of a diverse group of early childhood professionals, reviews all materials and decides to either grant or defer accreditation. Granting accreditation requires a unanimous decision. A deferment

[5]When programs are described as "meeting accreditation standards," they have not requested a validation visit and are not accredited. This language is common in child-care-related legislation; e.g., 1996 Defense Reauthorization Act.

must be accompanied by specific reasons and recommendations for improvement. Accreditation, when granted, is awarded for a three-year period.

ACCREDITATION IMPLEMENTATION CONTEXT

Implementation of the accreditation requirement—that 50 CDCs be accredited by June 1, 1991—was stymied by several factors. First, the implementing regulations for the MCCA were not published by the DoD until March 23, 1990 (U.S. DoD, 1990), and the service regulations did not follow until some months later. Given enormous concern about how to fund the many changes mandated by the MCCA, accreditation assumed at best a secondary status. Moreover, even in the best of circumstances, accreditation is a complicated and time-consuming process. As the June 1, 1991, deadline for accreditation loomed, the services concluded that there was little choice but to pursue accreditation of those centers most likely to successfully—and rapidly—attain it. Consequently, the initial group of accredited centers included a disproportionately high number of centers that were running high-quality and exemplary programs before accreditation.

Although facilitating the timely accreditation of the first 50 CDCs, the inclusion of many unusually well-run centers in the "demonstration program" undermined the ability to evaluate the effects of accreditation. If the best centers were also the first to become accredited, comparisons of accredited and nonaccredited centers would also be comparisons of better and less good centers. If the accredited centers produced better outcomes, there would be no way to determine whether the effect was due to accreditation, to the better initial center program, or to some unique benefit realized when already-good centers undergo the accreditation process. It is for this reason that the evaluation of the demonstration programs was reduced in scope and became one part of the overall implementation study.

ACCREDITATION RATES

The implementation difficulties facing the services did indeed prevent them from meeting the MCCA accreditation requirement of 50 CDCs accredited by June 1, 1991. Only 15 CDCs in our mail survey

had become accredited by the required date. Moreover, the distribution of accredited centers varied considerably, as shown in Table 11.1. The Marine Corps did not have any accredited CDCs, whereas the Army had eight, the Navy had six, and the Air Force had one.

Implementation improved over time. From June 1, 1991, through the end of 1992, an additional 40 CDCs represented in our survey sample were accredited. By the time of our mail survey (mid-1993), a total of 119 CDCs had become accredited, with more than 100 additional CDCs engaged in some part of the accreditation process.

As of October 1994, 315 CDCs across the DoD were accredited, or two-thirds of all eligible programs.[6] The distribution of accredited centers across the four services, however, remained varied. As shown in Table 11.2, the Air Force had almost all of its eligible programs accredited; the comparable Marine Corps figure was 14 percent.

These differences in accreditation rates are, to a large extent, the result of decisions by the Air Force and the Army to require universal accreditation. The Air Force decided, with high-level support, to require all Air Force CDCs to become accredited by a specified time. This goal and the considerable effort the Air Force expended to reach

Table 11.1

Number of Accredited CDCs by June 1, 1991, by Service

Service	No. of CDCs Accredited by 6/1/91	Percentage of Required No.
Air Force	1	7
Army	8	25
Marine Corps	0	0
Navy	6	69
Total	15[a]	26

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.07$ (F-test).

[6]Programs may be ineligible for accreditation for a number of reasons; e.g., a school-age-care component or imminent closure.

Table 11.2

Accreditation Rates, by Service, March 1997

Service	No. of Eligible Programs[a]	No. of Accredited Centers	Percentage Accredited Centers
Air Force	145	143	98
Army	155	126	81
Marine Corps	31	10	32
Navy	135	58	42
Total	466[b]	337	72

SOURCE: Data from DoD reports, 1997.

[a]Numbers here are less than the number of facilities, since several facilities may be accredited as one program.

[b]Total excludes ineligible programs.

it are laudable; nearly all Air Force CDCs had been accredited by the spring of 1996 (see Table 11.2). The Army's accreditation requirement did not have a deadline, because Army staff believed that although they wanted CDC staff to be working toward accreditation, they worried that a universal accreditation deadline would undermine the process. As shown in Table 11.2, the lack of a deadline, as might be expected, suppressed the Army's accreditation rate relative to that of the Air Force.

In contrast to the Army and the Air Force, the Marine Corps has developed no accreditation policy.[7] Over time, the Navy has adopted a policy that requires CDCs to do "all but validation." This policy requires that all Navy CDCs undergo the self-study process as if a validation visit would occur, but none is requested. Navy staff told us that the need to cover validators' travel expenses to centers outside the continental United States was the reason that the Navy has adopted its "all but validation" policy.[8]

[7]Both the Marine Corps and the Navy now require that every CDC be accredited.

[8]Navy Instruction OPNAVINST 1700.9C states that "Each center shall set achieving national accreditation as a goal or provide justification for not participating in this program." Without proactive enforcement, such language may have created ambiguity concerning the Navy's accreditation policy. A new Instruction (OPNAVINST 1700.9D) contributes to the ambiguity by stating, "Each center shall meet the standards for national accreditation by December 1996." Clarification of the existing policy ambiguity seems to be in order.

ACCREDITATION PROCESS

For the most part, the accredited centers in our sample embarked on the accreditation process at the behest of child development higher-ups. Indeed, nearly all survey respondents indicated that pressure to accredit had come from service headquarters or major command. As shown in Table 11.3, 80 percent of respondents indicated that they had gotten pressure from this relatively high level of the military structure to begin the accreditation process. Not surprisingly, virtually all Air Force respondents reported such pressure, which is consistent with the Air Force's strong accreditation policy. The percentage of respondents reporting pressures from above to accredit was weakest among Marine Corps respondents; not surprising given the Marine Corp's lack of a universal accreditation policy.

In some cases, the request received an enthusiastic response: Staff viewed it as a compliment and an opportunity to pursue a desired goal. In others, the response was less positive. CDC directors in these latter centers believed that the program was not ready and did not want to risk deferment. In a few centers, often those headed by a director without a B.A. degree, the request was met with a great deal of concern. These directors felt that they did not have the skills to direct the self-study and did not know how or where to begin. In a few instances, substantial staff resistance complicated the initiation of the self-study process. Although such resistance

Table 11.3

Percentage of Respondents Reporting Accreditation Pressure from Service Headquarters or Major Command, by Service

Service	Mean Percentage Pressured	Frequency
Air Force	94	68
Army	71	41
Marine Corps	57	7
Navy	70	37
Mean	80[a]	153

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

generally diminished over time, in a few centers staff who continued to protest accreditation had to be asked to leave.

TIME REQUIRED

Interviews with caregivers and CDC managers revealed that the accreditation process is indeed time-consuming and labor-intensive. Mail survey respondents reported that the initial accreditation process took an average one year from beginning to final completion, although some required as little as three months. The difference in the mean time to accreditation for those centers accredited before June 1, 1991, and those accredited from June 1, 1991, through 1992 was not statistically significant. There was, however, a statistically significant difference in the length of time to accredit between the last-accredited group of CDCs and the two earlier-accredited groups. The time required for the total initial accreditation process is presented in Table 11.4.

Table 11.4

Months Required for Accrediting First CDC

Accreditation Date	No. of CDCs	Mean Months to Accreditation	Range
Before June 1, 1991	16	8	3–12
Mid-1991 to 1992	39	10	3–24
1993	20	15	3–36
Overall total[a]	75	11	3–36

[a]The overall total here is less than the total number of accredited centers (N = 80) in the survey sample because of missing data.

SUPPORT AND TECHNICAL ASSISTANCE

Almost three-quarters of those survey respondents who had an accredited center on their installation or who were in the process of accrediting one reported that they had received some sort of assistance or support from service headquarters or major command. As shown in Table 11.5, the percentage indicating that they had received such assistance varied considerably by service, with Army and Air Force

Table 11.5

Percentage Reporting Receipt of Accreditation Assistance or Support, by Service

Service	Percentage Reporting Support or Assistance	No.
Air Force	79	34
Army	78	37
Marine Corps	33	3
Navy	53	17
Mean	73[a]	91

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.07$ (F-test).

respondents reporting assistance or support more frequently than the other two services.

Such cross-service differences are not surprising. They reflect differences in both organizational capacity and policy across the services. As noted above, the Army and Air Force both adopted universal accreditation policies, and through their major commands, closely monitored the accreditation process.

The Air Force also initiated a policy whereby a major command (MAJCOM) staff member would visit each CDC preparing for a validation visit at least twice. During the first visit, which would occur some time before the validation visit was anticipated, the MAJCOM visitor, who was a qualified NAEYC validator, reviewed the program description from the validator's perspective. From this perspective, the MAJCOM visitor would make suggestions for changes. She would then leave, during which time CDC staff worked to implement the suggested changes. The visitor then returned later to observe and discuss her reactions to the changes.

Air Force MAJCOM staff to whom we spoke were pleased with this policy. They were certain that it helped CDCs focus their energy and anxiety before the validation visit and increased the likelihood of a successful validation visit.

For the most part, mail survey respondents agreed that headquarters and major command accreditation support had been helpful, as shown in Table 11.6.

Table 11.6

Perceived Helpfulness of Headquarters and Major Command Accreditation Support, by Service

Service	Mean Helpfulness Rating[a]	No.
Air Force	1.7	26
Army	2.1	29
Marine Corps	1.0	1
Navy	2.0	8
Total	1.9[b]	64

SOURCE: Data from mail survey.

[a]1 = extremely helpful; 5 = not at all helpful.

[b]Means are not significantly different.

ALLOCATION OF RESPONSIBILITIES

The self-study process involved a substantial time commitment for center directors and training and curriculum specialists. These employees reported having spent from one-quarter to one-half of their time on accreditation during the self-study process. Some training and curriculum specialists told us that accreditation had taken all of their time during the most intense periods.[9] The CDP directors' involvement varied widely across installations, depending on the allocation of responsibilities and smoothness of the process. Usually, the CDP director would apply to NAEYC, promote accreditation to the staff, and finish the administrative evaluation. The construction of classroom scales and the completion of the staff and parent surveys would be carried out and overseen by the teachers, center directors, and training and curriculum specialists.

[9]This was generally not a problem because training and curriculum specialists redefined their job during this period as working toward achieving accreditation.

Work done for accreditation almost always took place during regular work hours, although one CDC director whom we interviewed in the field told RAND that she put in substantial time outside of regular center hours. Caregivers reported that they did this work during nap times, which were usually devoted to training activities. The division of labor and time allotted to accreditation in the centers visited by RAND were driven, at least in part, by the timeframe designated by the MCCA. Several CDP coordinators in early-accredited centers reported that they had set the pace of the self-study to comply with the June 1, 1991, MCCA deadline, even when the schedule felt tight.

Overall, most CDP administrators who had participated in a validation visit believed that the visit added considerable value to the self-study process. Knowing that people from outside the center and often outside the military would review staff ratings against what they themselves observed kept the self-study process more honest and more realistic, noted several respondents. One CDP director told us that she had used the anticipated validation visit to reorient a self-study process that had begun on a wildly congratulatory note. By reminding staff that more objective eyes would be viewing their efforts, she was able to get them to change uniformly highly positive ratings of everything to more varied and realistic ones.

EFFECTS OF ACCREDITATION

More Culturally Diverse Curriculum

The most commonly mentioned program deficiency revealed in the course of the self-study was a lack of multiculturalism in the curriculum. NAEYC requires that materials, images, and experiences at accredited centers reflect diverse cultures. To remedy the lack of multiculturalism, books that portray diverse cultures and multiracial dolls were purchased, and cultural holidays began to be celebrated.

Improved Caregiving

However, the most *significant* effect of accreditation was evidenced in caregiving activities. Analysis of child-caregiver interactions during the self-study process frequently revealed inappropriate activities on the part of caregivers, who had a tendency to be too directive.

Self-study resulted in more child-initiated and child-controlled activities.

Most CDC managers noted that caregivers' interactions with children were more thoughtful and respectful. There was less caregiver-directed and more child-directed activity. This led to a reduction in discipline problems in some centers. One child development coordinator told us that children talked more to each other, so that less communication placed the caregiver at the hub. Caregivers seemed to have a clearer sense about why certain things were done, and therefore felt more empowered to make both decisions and changes. Accreditation also resulted in activities better suited to particular age groups and in more age-appropriate disciplinary techniques. One CDC director, echoing the sentiments of many, believed that the accreditation process had opened staff eyes to true developmental care.

CDC staff members at nine of the installations with accredited centers reported that the self-study helped to clarify caregiving goals and helped caregivers to see that there was considerable room for improvement in how they related to the children. These insights led to significant motivation to improve. Many respondents noted that the age-focused child development training that the MCCA-mandated training and curriculum specialists had begun to provide helped "enormously." Because of the training, newly motivated staff had the skills they needed to make changes in the ways they interacted with the children.

Improved caregiver interactions with children were facilitated in at least some CDCs by significant changes in policies and operations that were motivated by the self-study process. One training and curriculum specialist, for example, noted that the NAEYC focus on developmental goals had substantially altered the way that ratios were maintained in her CDC. Before accreditation, ratios were maintained at minimal acceptable levels as a means of minimizing costs. Consequently, if staff were called in but not enough children showed up, staff would be sent home. Reconfiguring of groups occurred frequently throughout the day. Since accreditation, the focus has shifted dramatically, and management of ratios now includes the child's perspective. Minimizing costs is viewed as far less important than reducing transitions for children. Staff have also benefited from

the change, with more stability over the day for caregivers as well. In two other CDCs, efforts to minimize transitions led to a new policy, whereby caregivers begin with a group of infants and move with the children until age three. In one of these CDCs, attachment was also reinforced by the assignment of a primary caregiver to each child in each room.

Although we asked directly, CD staff had difficulty describing the effects of accreditation on child outcomes. For most, there was a sure sense that children had benefited and continued to benefit from accreditation. But most of these benefits were inferred—from better equipment, more group stability over the course of the day, higher staff morale, and a clearer sense of key developmental goals. Like parents, staff were certain that all these changes were good for children, but they had no objective means of supporting these views.

Increased Prestige and Recognition

The prestige of accreditation and the recognition for having met a nationally recognized standard were the most frequently reported benefits among interviewees. CD directors noted that increases in staff morale were linked to achieving a national standard.

In some locations, accreditation conferred status on programs that had suffered in esteem because of an older or less than optimal physical plant. On several installations with multiple centers, CDC decisionmakers had chosen to accredit centers jointly, so that the program in the older facility would benefit as well from the NAEYC imprimatur. In a few cases, this decision was challenged by military personnel, who pressured CDC directors to attempt accreditation of the program housed in the newer facility first, as accreditation of this program was likely to be faster and cheaper to accomplish. In every such instance we learned of, CDC personnel prevailed; they reported that the program in the older plant had benefited from the joint accreditation.

The recognition of a quality program can also improve parent attitudes toward military child care. Respondents on several installations reported improved parent involvement as a result of accreditation, which is one of NAEYC's goals. In several centers, this came about because of a new policy of semiannual or quarterly caregiver-

parent conferences. Achieving accreditation also helped boost opinions of child care in the military community.

The responses from the mail survey were very consistent with the views expressed in the installation interviews. Overall, the effects of accreditation were described as very positive. Of the 80 installations with one or more accredited centers, at least 75 percent responded that accreditation had improved staff morale, the definition of goals, and the overall quality of care, as shown in Table 11.7. In the majority of cases, accreditation had led, in the respondents' view, to increased prestige in both the military and civilian communities, and had generated approval from military superiors. Only 3 percent of the responding installations reported that the accreditation process had incurred disapproval from military superiors. Our fieldwork data suggest that in some cases, disapproval stemmed from command beliefs that more stringent NAEYC requirements would make the center more costly to run.

Table 11.7

Survey Responses on Effects of Accreditation (N = 80)

Reported Changes Resulting From Accreditation	Percentage Reporting Noted Change	No. of Responses
Higher staff morale or pride	93	74
Better-defined goals	88	70
Higher-quality care	79	63
Greater respect in military community	75	60
Greater respect in civilian community	73	58
More innovative or child-centered program	70	56
Approval from superiors in military	69	55
Improved child outcomes	60	48
Greater parent involvement	41	33
Disapproval from superiors in military	3	2

SOURCE: Data from mail survey.

CONCLUSIONS

The effect of accreditation was judged by nearly all to be overwhelmingly positive. Both mail survey respondents and CDS staff interviewed in person report a large number of beneficial effects of accreditation. The most frequently cited benefit among survey

respondents was higher staff morale and pride. The second most frequently cited set of benefits related to program improvements such as better-defined goals, higher-quality care, and more innovative programs. Greater respect and approval from the civilian and military communities were also frequently cited as valuable benefits of accreditation. Improved child outcomes were cited by fewer respondents than the other benefits but still by more than half. It is interesting to note that even the first centers to be accredited—most likely the best-run ones—reported a positive effect of accreditation in terms of staff morale and pride and in terms of better definition of program goals.

Although it has not been possible to directly measure the effect of accreditation on child outcomes, there can be little doubt that accreditation improves the quality of care provided, not only in those centers with lower pre-accreditation quality of care but also in initially high-quality centers. The heavy focus on caregiver-child interactions in the self-study process and the emphasis on standards as a means of achieving important child-centered goals necessarily affect how caregivers interact with children, with parents, and with each other. Policy changes consistent with child-centered goals reinforce changes at the caregiver level in some CDCs as well.

Studies of child development have found significant relationships between quality of care and child outcomes across a range of domains, including cognitive development, language skills, and social development. These studies have shown child-caregiver interactions to be of particular importance for child outcomes. Since accreditation is designed to particularly improve this aspect of care, it is reasonable to conclude that accreditation results in improved child outcomes, although empirical validation is still needed.

Respondents disagreed about whether the benefits of accreditation outweigh its costs; no one could cite data supporting his or her position.[10] But it is clear that in many respects, the implementation of

[10]The only incremental costs of accreditation are the application and validator fees charged by NAEYC. (Outside the continental United States, validator travel costs must also be paid.) Virtually all necessary program and facility changes identified during the self-study process need to be made to meet DoD certification requirements in any case. (See Zellman, Johansen, and Van Winkle, 1994, for further discussion of the costs of accreditation.)

the MCCA has substantially reduced the costs of accreditation. In particular, the mandated training and curriculum specialist position has provided each CDC with at least one person with a strong child development background who can devote a substantial portion of her time as needed to accreditation-related activities. Required caregiver training has increased the skill level and knowledge base of caregivers. The salary increase that caregivers won through the MCCA has increased both the quality and longevity of caregiving staff.[11]

Given minimal incremental costs for accreditation and substantial apparent benefits, we conclude that universal accreditation of CDCs is a desirable and achievable goal. Indeed, as accreditations are achieved in initially less-able CDCs, we have every reason to expect that the benefits of accreditation for military children will become increasingly apparent.

[11]See Zellman, Johansen, and Van Winkle (1994) for data on these points.

Chapter Twelve

UNDERSTANDING MCCA IMPLEMENTATION

The previous chapters discussed in great detail the implementation of the key provisions of the MCCA. The goal of this chapter is to summarize and reconcile our findings with what we expected based on the implementation model developed in Chapter Two.

THE IMPLEMENTATION PROCESS: OVERALL STATUS

One of the most noteworthy findings of our analysis of the implementation of the MCCA is the high level of implementation of most of the act's provisions. Most survey respondents reported that these provisions had been implemented by the completion of the data collection phase of our study (August 1993). Not surprisingly, some of the more difficult provisions of the act were not as fully implemented as other less complex ones.

Table 12.1 gives an overview of the implementation status of key MCCA provisions, as reported by our mail survey respondents in mid-1993. This table summarizes the salient aspects of the implementation process. The first column lists the relevant provision of the MCCA. The second column describes the implementation status of the provision, based on mail survey results. Typically, this column indicates the percentage of mail survey respondents who reported that their installation had implemented the particular provision. For example, the entry concerning the APF match is the percentage of mail survey respondents who reported that their installation had met the required APF match at the time of the survey. The inspection and certification entry notes the percentage of mail survey respondents who indicated that their program had achieved

Table 12.1

Overview of Implementation Status and Implementation Difficulty, as of August 1993

Provision of the MCCA	Implementation Status (%)	Implementation Difficulty
Appropriated funds match	66	Difficult
Caregiver pay program	100	Easy
Parent fee policy	100	Easy
Inspection	100	Difficult
Certification	80	Difficult
T&C specs hired	74 (of positions filled)	Intermediate
New GS positions	9 per installation	Difficult
GS positions filled	40	Difficult
Parent boards	96	Easy
FCC subsidies	16	Easy
Accreditation by 8/93	119 CDCs (26 percent of all CDCs in mail survey)	Intermediate

SOURCE: Data from mail survey.

certification. The "T&C specs hired" entry indicates the percentage of T&C spec positions that respondents reported were filled at the time of the mail survey; similarly for the GS positions. In addition, the table also indicates how many GS positions resulted from the MCCA.

The third column describes the overall level of implementation difficulty. This rating reflects the implementation experience evidenced in our three sources of data (mail survey, field data, document abstraction). Because our data come from different sources that are not always quantifiable, we employ a relatively simple rating scale with three ratings: difficult, intermediate, and easy. Implementation was rated difficult if all the available data indicated that the process had been difficult; an easy rating was given if the data consistently indicated that the provision had caused no particular problems. An intermediate rating was given if we found mixed evidence concerning the degree of difficulty across or within data sources.

As shown in Table 12.1, one of the most difficult provisions of the act was meeting the 50 percent APF match, which only two-thirds of re-

spondents reported they had done at the time of our survey.[1] Some of the less-difficult aspects of the act—the caregiver pay program and the parent fee schedule—were fully implemented at the time of the survey. The inspection program was also fully implemented in the sense that all installations were being inspected. However, 20 percent of the respondents to our mail survey reported that their program was not yet certified.

Similarly, the caregiver training program and the hiring of T&C specs were also fully implemented in theory, although in practice only about three-quarters of the respondents reported having filled all their T&C spec positions at the time of our mail survey. Likewise, not all the caregivers who were supposed to have completed the training modules under the caregiver pay program had actually done so.

Survey respondents reported that GS caregiver positions had been established everywhere, but again, to varying degrees. On average, respondents reported an additional nine GS positions after the implementation of the MCCA. However, only 40 percent reported having all their GS positions filled at the time of the survey.

Parent boards were reported on 96 percent of the installations, in spite of a widespread perception that this was one of the least important provisions of the act.

In contrast, the FCC subsidies that were allowed by the act were not implemented by most of the services and installations. Only 16 percent indicated that they had implemented this provision of the act. This is not surprising, given that it was one of the act's few optional provisions. Finally, at the time of our mail survey, respondents reported that a total of 119 CDCs (26 percent of the 466 CDCs represented in our mail survey) were accredited, with more than 100 additional CDCs in the process of seeking accreditation.

In summary, our data reveal a very high level of implementation of MCCA provisions. This was to be expected on the basis of what we knew about the policy instrument, the military, and implementation research.

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[1]DoD sources indicate that the match had been met overall by then; our findings may reflect lack of a match on *individual* installations.

First, the MCCA was written and passed by Congress. Whatever their views of Congress (and they varied substantially), fieldwork interviewees understood that when Congress spoke, the military saluted. Even though Congress certainly hobbled implementation of the MCCA by failing to provide an appropriation and by requiring rapid, mid-year implementation, Congress would be obeyed.

Second, the policy instrument that Congress used was a mandate. As discussed above, mandates seek uniform but minimal compliance (McDonnell and Elmore, 1987). Compliance is best achieved by performance-monitoring, since implementors may not always be committed to implementation, a point that we return to below. Congress in its wisdom built into the MCCA a system of compliance-monitoring in the form of the four required annual inspections of CDCs. In addition, it required periodic briefings and progress reports from the DoD on the status of the implementation process to ensure that noncompliance would be detected and remedied. These components, combined with the nature of its progenitor, accounted for a major share of successful implementation of the MCCA.

Third, the military, the MCCA's implementing organization, is hierarchical and very used to following orders from up the chain. Although the fact of the MCCA's being imposed from the outside unquestionably decreased attitudinal support for the MCCA, whether that lack of support would evidence itself in unsupportive behavior depended heavily on how the military reacted to the policy change. Those responsible for moving implementation forward at the various levels (headquarters, major commands, installations) spent a good deal of time testing the waters in the beginning to see how the military would respond as an organization to what many perceived as an assault on its autonomy and on its mission (since APF$ would now be siphoned in significant quantities out of "military" activities and into child development). The documents that we reviewed are replete with questions and statements that indicate at best a reluctant partnership between Congress and the military on the MCCA (Stoker, 1991). We found a high level of testing by the services and especially by installation representatives that ranged from efforts at apparent clarification, e.g., "is the APF$ match a target or a floor?" to more straightforward defiance, e.g., "we will not implement this provision unless funds are forthcoming," when they knew that they were not.

The services headquarters documents that we abstracted suggest that at the highest levels of the DoD (and in formal documents), support for the MCCA and its implementation was in place from the beginning of the implementation process. There was certainly evidence of questioning, but the questioning appeared largely to be in the service of clarification rather than defiance. There are several possible reasons for this stance. One may be that DoD and Congress shared similar goals for child development. Although DoD and the services testified against the MCCA during Congressional hearings, DoD respondents told us later that they opposed the act not out of opposition to its goals, but because many of them were already being included in a new DoD Instruction that was under way, so that Congressional intervention was not necessary.

Another reason why the DoD seemed to move forward quickly may have been that the engine for implementation of the MCCA at the DoD level comprised the four service child care managers who were called in early on by the DoD to help in the implementation effort. These women had a strong intellectual and emotional commitment to child development and were enthusiastic in their support of the MCCA after its passage. They acted as "fixers" during the implementation process, working hard to smooth the process, provide support, and move the effort forward (Levin and Ferman, 1986). In Goggin's (1987) terminology, these women could be considered "program champions," an important factor in ensuring implementation.

Finally, champions in the DoD were able to realize their program implementation goals because civilian appointees at the highest levels of the DoD were clearly in charge. The sometimes uneasy balance between the military and the civilians in the DoD had shifted at the time of the MCCA's passage to civilians under two strong Republican presidents who were not defensive about their own military histories. Some of these civilians supported the MCCA's goals; others supported its implementation because it was the law of the land. But whatever the basis for their MCCA support, the political side of the house was firm in standing up for the MCCA against a phalanx of uniformed opposition.

At the same time, the high degree of implementation of the various provisions of the act masks important differences in the length of time and degree of difficulty associated with their implementation.

These differences tell an important story about the implementation process that should not be ignored.

Column 3 of Table 12.1 provides a summary of the degree of difficulty associated with the implementation of the various aspects of the MCCA, based on survey and fieldwork data. Not surprisingly, it reveals a mixture of difficult, intermediate, and easy implementation processes, reflecting the inherently different nature of the various provisions.

In general, we found that the easier the implementation process, the greater the degree of implementation of a specific provision. This, of course, is not unexpected.

APF Match

The APF match was one of the most difficult MCCA provisions. Our survey respondents told us that it had not been achieved on a substantial percentage of installations by mid-1993. Among those installations that had achieved the match, there was considerable variation in the time it took to first meet it. Only 16 percent of mail survey respondents reported that their installation had met the match in FY90. Another 34 percent of those who met the match had first met it in FY91, 36 percent of those that had met it had first done so in FY92, and the remaining 12 percent of installations that had met the match had first met it in FY93.

We asked our mail survey respondents whether the APF$ available were sufficient and, not surprisingly, only 31 percent indicated that they had had sufficient APF$ available in FY90. This percentage increased steadily to 66 percent by FY93, mirroring the percentage of respondents able to meet the required APF match.

In our fieldwork, we heard over and over again that without question, APF was one of the most difficult aspects of the act to implement, although there were differences in the degree of difficulty experienced (see below for a discussion of differences by service).

The considerable difficulty experienced in implementing the APF match is also apparent in documents abstracted from services headquarters. The most frequently addressed topic in these documents was funding (see Table 3.2). Many of the abstracted documents fo-

cused on where the money to support the MCCA was to come from. A number of documents questioned the status of various MCCA provisions as a means of reducing the financial burden.

In short, all the evidence points to a long and difficult implementation process to implement the APF match requirement. This difficulty is not surprising for several reasons. First, with the exception of the Army, the level of APF$ going to child care had to increase dramatically to equal parent fee revenues. Second, the military services were beginning the post-Cold War drawdown as MCCA implementation got under way, which reduced the overall budget. This made it even more difficult to find additional APF$ for child care. Related to the drawdown were a number of hiring freezes, which exacerbated the difficulties in hiring GS staff, the main mechanism to increase APF. And third, getting regular APF$ through the POM is a lengthy process, requiring up to three years of planning.

Caregiver Pay Program/Parent Fees

In contrast, both the caregiver pay program and the parent fee policy were easy to implement, and full implementation was achieved relatively early. The caregiver pay program was implemented by half the installations represented in the mail survey by June 1990, and by 75 percent by September 1990; less than 1 percent of the respondents had not implemented the caregiver pay program by the time of the mail survey in mid-1993.

The implementation timetable for the parent fee policy was quite similar to that for the caregiver pay program. Half of mail survey respondents reported that their installation had implemented the fee policy by October 1990. By June 1991, 75 percent had done so, and by March 1993, implementation of the parent fee policy was 99 percent accomplished, according to mail survey respondents.

Despite the speed and relative ease of implementation of these two provisions of the MCCA, relatively minor implementation difficulties were reported in several fieldwork sites. In particular, a few CDC directors reported having had to fire caregivers who failed to complete the training tied to pay increases under the caregiver pay program.

We were also told of some parent opposition to the new fee policy among those in higher fee categories that resulted in some high-income parents removing their children from CDCs. In most places, however, this opposition was transitional, and many of these children, if they left at all, reenrolled in the CDC over time.

Inspections and Certification

In contrast to the caregiver pay program and the parent fee policy, implementation of the inspection program was considerably more difficult, although the degree of difficulty varied with the specific component. Implementation of the inspections themselves was considerably less difficult than achieving certification, which presented a number of difficulties on many installations, as evidenced by the 20 percent of installations which our survey respondents reported had yet to achieve certification at the time of our mail survey.

An additional measure of the difficulty encountered in achieving certification is the percentage of mail survey respondents who reported that one or more CDCs had been closed on their installation as a result of no-notice inspections. Eight percent reported such closures; half of these closures resulted from facility deficiencies, and about one-third resulted from program deficiencies.

We asked our mail survey respondents to rate the degree of difficulty they had experienced in making the program and facilities changes required for MCCA implementation and for certification. Forty-one percent reported that the program changes were difficult or extremely difficult, with an additional 33 percent reporting that program changes had been somewhat difficult. Facility changes were reported as difficult or extremely difficult by just over half of the respondents, with an additional 28 percent reporting them to be somewhat difficult.

Our field data confirm these results: Many interviewees indicated that facility changes were more difficult than program changes, largely because they required money and the cooperation of other proponencies. Combined, these results indicate that the implementation of the inspection and certification provision of the MCCA was difficult and drawn out.

Hiring of Training & Curriculum Specialists

The MCCA required that a T&C spec be hired at each CDC. Our field data indicate that initial establishment of T&C positions themselves had not been extremely difficult, although the effort had met with some resistance in certain places from military staff who could not see the need for a T&C specialist at each CDC. Nevertheless, one-quarter of the installations included in our mail survey reported having vacant T&C positions. Those with a vacant position indicated that difficulties in hiring GS staff, lack of funds, and lack of qualified staff, in descending order, were the major reasons why some T&C spec positions were unfilled.

The ease of implementation of the GS positions mandated by the MCCA was closely related to the successful implementation of the APF match because the latter's APF$ would be used to fund the GS positions. As described above, the APF provisions were very difficult to implement, and as a consequence so were the GS positions.

Once established, keeping GS positions filled has not been easy. Indeed, 60 percent of positions were vacant at the time of our mail survey, according to respondents. These hiring difficulties are apparent in the much longer time period required to fill GS positions (3.1 months) than NAF positions (1.1 months).

Parent Boards/FCC Subsidies

Implementation of parent boards was easy and largely painless, despite the fact that almost two-thirds of the installations reported that they did not have a parent board before the MCCA. This is no doubt because their creation required neither additional staff nor funds. Indeed, parent boards represented a significant new resource to a few CDCs where members served during duty hours. Similarly, the provision that authorized direct subsidies for FCC providers was relatively painless, because it went largely unimplemented. In the few places where subsidies were actually provided, the main issue was the interpretation of what was required and allowable under the provision in the absence of clear guidance.

Accreditation

The accreditation requirement was not easily achieved. In fact, it had been impossible to meet the deadline for the 50 demonstration centers written into the MCCA. Even centers that had achieved accreditation reported that it had been a time-consuming and somewhat difficult process (see Zellman, Johansen, and Van Winkle, 1994). On average, mail survey respondents reported that it took just under a year to achieve accreditation although a small proportion of respondents reported a considerably longer accreditation period.

Several of our fieldwork interviewees indicated that it had been difficult to achieve accreditation, although many others reported that, although it had been time-consuming, accreditation had not been all that difficult. Much depended on the level of support from installation command, major command, or service headquarters.

Almost 75 percent of our mail survey respondents indicated that they had received some kind of assistance or support from headquarters or the major command (where relevant) in achieving accreditation. Of those receiving such support, 70 percent described this as either "quite" or "extremely" helpful, indicating that the accreditation process was not a trivial one.

Summary

Our analyses confirm that the MCCA's provisions were implemented at a high rate across the DoD. This high overall rate of implementation largely reflects two key aspects of the model presented in Chapter Two: the nature of the policy change and the policy context.

The model includes five aspects of a policy change that are likely to affect implementation: the type of policy instrument, the validity of the causal theory, the extent of behavioral change required, the ability of the statute to structure implementation, initial allocation of financial resources, and the perceived value of the new policy to the organization. The fact that the MCCA was a mandate and the high degree to which the law structured implementation (especially with regard to the achievement of its increased quality goal) were particularly important in facilitating implementation.

The model also described three aspects of the policy context that may affect implementation: the military as an organization, downsizing, and military relations with Congress. Although downsizing worked against support for the MCCA, the military's hierarchical, rule-driven nature dominated the context and promoted overall implementation.

At the same time, our analyses of the separate MCCA provisions presented above reveal many differences across the services in implementation experiences and outcomes. These differences are best explained by the latter two components of our implementation model—the implementation process and the local context for change, which varied, sometimes dramatically, by service. In the next chapter, we provide an overview of MCCA implementation in each service, then highlight and explain observed differences as a function of differences in the implementation process and the local context for change.

IMPLEMENTATION WITHIN THE SERVICES

To provide a succinct overview of the implementation process in each service, we constructed a table for each service which contains the same categories of information reported for the DoD as a whole in Table 12.1. The single difference from Table 12.1 is the addition of a column that ranks that service's implementation status relative to the other services on each provision. This ranking is based on survey data displayed in column 2. For example, with 77 percent of the Army installations represented in the survey reporting that they had met the required APF match, the Army ranks first among the four services on implementation of this provision of the MCCA. In contrast, it ranks last (fourth) on the percentage of installations with parent boards.

Because the results in the table are reported on a servicewide basis, the results may obscure differences across installations within a service. For example, when the parent fee policy is reported to have been implemented with ease, this does not mean that there may not have been installations on which parent opposition to the policy slowed or complicated its implementation. Rather, the rating indicates that overall, the evidence suggests that this provision generally was implemented in this service without particular difficulties.

Implementation in the Army

As shown in Table 12.2, the Army had achieved extensive compliance with almost all provisions of the MCCA at the time of our mail survey. According to survey respondents, more than three-quarters of the CDP programs had met the required APF match, most were certified, and 89 percent had parent boards. Almost half of the CDP programs reported providing FCC subsidies; the caregiver pay program and the parent fee policy were fully implemented everywhere. Although positions for T&C specs and GS positions were established widely, they were frequently not filled. In contrast, a relatively large number of CDCs were accredited or in the process of getting accredited, reflecting the Army's universal accreditation policy.

Table 12.2

Overview of Army Implementation Status and Implementation Difficulty

Provision of the MCCA	Implementation Status (%)	Interservice Rank	Implementation Difficulty
Appropriated funds match	77	1	Easy
Caregiver pay program	100	(a)	Easy
Parent fee policy	100	—	Easy
Certification	85	2	Difficult
T&C specs hired	63	4	Intermediate
New GS positions	18 positions[b]	2	Intermediate
GS positions filled	19	4	Intermediate
Parent boards	89	4	Easy
FCC subsidies	46	1	Easy
Accreditation before 6/1/91	8 CDCs (35 percent of required number)	2[c]	Difficult
Accreditation by 8/93	43 CDCs (31 percent of all CDCs)	1[d]	Intermediate

SOURCE: Data from mail survey.

[a]In cases where each service had 100 percent implementation of a given provision, no rank-ordering was possible.

[b]This figure represents an installation average.

[c]Rankings for the accreditation provisions are based on the degree to which each service met their accreditation obligation under the demonstration program in the MCCA.

[d]Rankings are based on the percentage of all CDCs in that service that were accredited at the time of the survey.

Relative to the other services, the Army had achieved a high level of MCCA implementation, as evidenced by its interservice rankings for the different provisions. The Army's high ranking on the more difficult provisions of the MCCA—the APF match, certification, and accreditation—is particularly noteworthy. Moreover, the implementation process for almost all provisions was relatively easy in the Army.

Implementation in the Navy

As shown in Table 12.3, the Navy had achieved a high level of implementation of many of the MCCA's provisions, although for a few, its implementation lagged. About half the installations had met the required APF match, nearly all reported being certified, and the caregiver pay program and the parent fee policy had been implemented universally. Three-quarters of the T&C spec positions were filled, but

Table 12.3

Overview of Navy Implementation Status and Implementation Difficulty

Provision of the MCCA	Implementation Status (%)	Interservice Rank	Implementation Difficulty
Appropriated funds match	51	4	Difficult
Caregiver pay program	100	(a)	Easy
Parent fee policy	100	—	Easy
Certification	89	1	Intermediate
T&C specs hired	75	3	Intermediate
New GS positions	15 positions	3	Difficult
GS positions filled	43	2	Difficult
Parent boards	99	2.5	Easy
FCC subsidies	4	3.5	Difficult
Accreditation before 6/1/91	6 CDCs (67 percent of required number)	1[b]	Difficult
Accreditation by 8/93	25 CDCs (19 percent of all CDCs)	3[c]	Intermediate

SOURCE: Data from mail survey.

[a]In cases where each service had 100 percent implementation of a given provision, no rank-ordering was possible.

[b]Rankings for the accreditation provisions are based on the degree to which each service met their accreditation obligation under the demonstration program in the MCCA.

[c]Rankings are based on the percentage of all CDCs in that service that were accredited at the time of the survey.

almost 60 percent of the GS positions were vacant. Ninety-nine percent of installations had parent boards, but only 4 percent had implemented some kind of FCC subsidies. Six CDCs were accredited before the June 1, 1991, deadline, making the Navy the early accreditation leader, but only an additional 19 had become accredited by the time of the mail survey, reflecting the Navy's lack of a universal accreditation policy.

The Navy's implementation process was relatively difficult, as reflected both in the difficulty ratings assigned to the particular provisions and in the interservice rankings of implementation status.

Implementation in the Marine Corps

The implementation of the MCCA in the Marine Corps was fraught with difficulties and delays. As a result, compliance with the provisions of the act lagged behind that of the other services. Although parent boards, the caregiver pay program, and the parent fee policy were implemented fully, less than half of the installations reported certified programs, less than two-thirds had met the required APF match, only 38 percent of GS positions had been filled, and only 8 percent had implemented any FCC subsidies at the time of the mail survey (see Table 12.4). Furthermore, no CDC had become accredited by the June 1, 1991, deadline, and only two CDCs became accredited subsequently, reflecting the Marine Corps' lack of a universal accreditation policy. The one bright spot was that more than 90 percent of the T&C spec positions were filled at the time of our mail survey.

The Marine Corps' difficulties in implementing the act are further reflected in the difficulty rating for the individual provisions, which to a much greater extent are rated as difficult, as well as in the interservice rankings, where the Marine Corps typically received the lowest or second-lowest ranking.

Implementation in the Air Force

As shown in Table 12.5, the Air Force had implemented many of the MCCA's provisions to a considerable extent at the time of the mail survey. More than 70 percent of the installations had met the

Table 12.4

Overview of Marine Corps Implementation Status and Implementation Difficulty

Provision of the MCCA	Implementation Status (%)	Interservice Rank	Implementation Difficulty
Appropriated funds match	62	3	Difficult
Caregiver pay program	100	(a)	Easy
Parent fee policy	100	—	Easy
Certification	46	4	Difficult
T&C specs hired	92	1	Intermediate
New GS positions	23 positions	1	Difficult
GS positions filled	38	3	Difficult
Parent boards	100	1	Easy
FCC subsidies	8	2	Difficult
Accreditation before 6/1/91	0 CDCs (0 percent of required number)	4[b]	Difficult
Accreditation by 8/93	2 CDCs (6 percent of all CDCs)	4[c]	Difficult

SOURCE: Data from mail survey.

[a]In cases where each service had 100 percent implementation of a given provision, no rank-ordering was possible.

[b]Rankings for the accreditation provisions are based on the degree to which each service met their accreditation obligation under the demonstration program in the MCCA.

[c]Rankings are based on the percentage of all CDCs in that service that were accredited at the time of the survey.

required APF match, almost three-quarters reported having achieved certification, 79 percent of the T&C spec positions were filled, and 99 percent of the installations had parent boards. In addition, the caregiver pay program and the parent fee policy were fully implemented. In contrast, only about half of GS positions were filled, and only 4 percent of the installations reported providing some kind of FCC subsidy. This latter finding no doubt reflects an Air Force decision not to authorize them. Accreditation of CDCs before the June 1, 1991, deadline was very slow; only one CDC made the deadline. Since then, however, the Air Force's universal accreditation policy, which was tied to a deadline, has resulted in virtually all CDCs becoming accredited; it ranked second on this provision at the time of our survey.

Table 12.5

Overview of Air Force Implementation Status and Implementation Difficulty

Provision of the MCCA	Implementation Status (%)	Interservice Rank	Implementation Difficulty
Appropriated funds match	71	2	Difficult
Caregiver pay program	100	(a)	Easy
Parent fee policy	100	—	Easy
Certification	74	3	Difficult
T&C specs hired	79	2	Intermediate
New GS positions	12 positions[b]	4	Intermediate
GS positions filled	54	1	Intermediate
Parent boards	99	2.5	Easy
FCC subsidies	4	3.5	Difficult
Accreditation before 6/1/91	1 CDC (7 percent of required number)	3[c]	Difficult
Accreditation by 8/93	48 CDCs (30 percent of all CDCs)	2[d]	Intermediate

SOURCE: Data from mail survey.

[a]In cases where each service had 100 percent implementation of a given provision, no rank-ordering was possible.

[b]This figure represents an installation average.

[c]Rankings for the accreditation provisions are based on the degree to which each service met their accreditation obligation under the demonstration program in the MCCA.

[d]Rankings are based on the percentage of all CDCs in that service that were reported by survey respondents to be accredited at the time of the survey.

The Air Force experienced considerable difficulties in implementing the MCCA, as evidenced by the difficulty ranking in Table 12.5. Although some of the ratings are easy, several are difficult or intermediate. Relative to the other services, the Air Force ranks in the middle, with rankings of second or third, behind either the Army or the Navy.[2]

In short, the implementation process varied substantially across the four services. Generally speaking, the Army had the highest level of compliance with MCCA provisions and the easiest implementation experience. In contrast, the Marine Corps had the lowest level of compliance and the most difficult implementation experience. The

[2]The Air Force's universal accreditation policy caused dramatic change. At this writing, only one CDC remains unaccredited.

Navy and the Air Force fell between these two extremes, in terms of both the extent of compliance and difficulty ratings.

Understanding Interservice Differences

What accounts for the above documented interservice differences in compliance with the provisions of the MCCA and in the implementation process experienced by each service? To answer this question, we return to the implementation framework discussed in Chapter Two. This framework describes four different factors that we hypothesized would influence policy implementation: the nature of the policy change, the policy context, the implementation process, and the local context for change. Each of these factors includes a variety of dimensions relevant to policy change in the military. Some of these factors would be expected to vary across the services and others would not; we focus on those factors that vary across the services.

FACTORS INFLUENCING POLICY IMPLEMENTATION

The Nature of the Policy Change

The first factor described in our policy implementation framework in Chapter Two concerns the nature of the policy. Included in this factor are a variety of dimensions related to the policy itself: the type of instrument, validity of the causal theory behind the policy, the extent of behavioral change needed, the ability of the statute to structure implementation, initial resources, and perceived value of the new policy to the organization.

For obvious reasons, many of these dimensions are more relevant in explaining overall DoD implementation than differences across the services. In particular, characteristics of the legislation itself—the type of instrument, the lack of Congressional appropriation of resources, the validity of the causal theory, the ability of the statute to structure implementation—did not vary across the four services. The remaining factors did vary to some extent across the services and are discussed in more detail below.

The Extent of Behavioral Change Required

The extent of behavioral change required influences implementation in the same way an obstacle to implementation would. The greater the behavioral change required, the more difficult the implementation process, and as a result, the slower and less complete the implementation may be.

All the evidence points to significant differences across services in the extent of behavioral change required. These differences resulted from the different status and capacity of child development programs in each service at the outset of the implementation process.

The Army was clearly the service in the most enviable position. It had the most well-developed and well-funded CDP program before the MCCA. Furthermore, some of the provisions in the act were more or less modeled after CDP activities in the Army (e.g., T&C specs), giving the Army an additional advantage over the other services, and giving it "leader" status (Goggin et al., 1987). Finally, the Army's commitment to CDP pre-MCCA was very strong, as evidenced by the responses to our mail survey concerning command support for the MCCA, where the Army received the highest support rating (results not shown). As a result, the amount of behavioral change required by the Army was less than that required by the other services at the same time as it had the most capacity to make needed changes.

In contrast, the Marine Corps needed to change drastically in a number of areas. It had no ongoing inspection program when the MCCA was passed. It had no T&C specs, few APF$ going to CDP programs, and very limited staffing at headquarters. In addition, the program operated in a context in which doing more with less was expected and valued (Builder, 1996). Clearly, the Marine Corps was a "laggard" (Goggin et al., 1987). The other two services occupied intermediate positions. The Navy had developed the training models that the Army had adopted but had a limited inspection program. The Air Force had a long-standing comprehensive program of inspections tied to the USDA food program.

Thus, part of the differences in the ease and speed with which the four services implemented the various provisions of the MCCA may be explained by differences in the extent of behavioral change required, which varied considerably across the services.

Initial Resources

Because the MCCA did not come with accompanying resources (i.e., appropriated funds), the services were forced to rely on their own resources to implement the act in the early years. Because the services varied markedly in their pre-MCCA funding of child care, the effect of the lack of appropriated funds for implementation of the MCCA varied considerably across the services. The service with the greatest amount of APF$ before the MCCA (the Army) was in a better position to find the required APF, whereas the service with the fewest APF$ before the MCCA (the Marine Corps) was in the most difficult position. These differences in pre-MCCA funding levels are reflected in the ability of the services to execute the required APF, as seen in Table 12.6.

The lack of initial funds was a major contributor to cross-service differences that persist today. Well-endowed programs, which reflected more service-level support, could count on more resources, but programs that had struggled pre-MCCA, while grateful for the infusion of support, remained relatively disadvantaged during MCCA implementation.

Perceived Value of New Policy to Organization

Another factor potentially influencing the implementation of a policy is the perceived value of the new policy to the organization. For obvious reasons the greater the perceived value of a new policy, the more likely the organization is to implement the policy. Although we have little direct evidence concerning this point, certain indicators point to differences across the services in their perception of the value of the MCCA.

The extent to which the provisions of the MCCA mirrored prior service policy is an indirect indicator of the extent to which the service valued the new policy. The greater the overlap between preexisting service policies and the MCCA, the more reasonable it is to assume that the service valued the goals and means of the act. On this basis, it is clear that the Army and, to some extent, the Navy would perceive the value of the MCCA as greater than either the Air Force or the Marine Corps.

Table 12.6

Services' Status on Key Implementation Indicators

Service	Officials' Commitment to MCCA	Execution Rates of APF$ Directed by the MCCA as of 3/31/90 (%)	Early Implementation Guidance Clarity and Specificity	Dominant Early Implementation Style
Air Force	High-level command exhortations to implement and spend	9	Following DoD lead, indicated that floors were targets, later changed message	Delay/strategic delay
Army	High	49	Two-page table of implementation requirements, responsible entity, and HQ POC	Compliance
Marine Corps	Some implication that full compliance not required at first. Later, some exhortation to comply	13	Indicated that full MCCA implementation not requirement in first year(s). Important error in funding guidance	Defiance/delay
Navy	Reminder that repeat deficiencies that result in closings must be reported to Congress. Navy HQ memos remind major claimants of adequate funding to implement, must do so	38	No plan for increased child care availabilty	Delay/ compliance

SOURCE: Entries from document abstraction.

Other evidence also suggests differences in the perceived value of the policy that are, to some extent, independent of service policies or stance. In particular, the amount of interest in and active monitoring of the implementation process by high-ranking military personnel varied across the services. Our abstraction data reveal that in both

the Army and the Air Force, a few high-ranking generals took a personal interest in the implementation of the MCCA and actively monitored and enhanced the progress of particular provisions, e.g., accreditation.

In summary, although the evidence is indirect, it is apparent that the services differed in their perceived value of the MCCA, with the Army at one extreme and the Marine Corps at the other. These differences contribute to observed differences across the services in the degree of difficulty experienced implementing the MCCA.

THE POLICY CONTEXT

The second factor described in our policy implementation framework in Chapter Two concerns the policy context. This factor includes a variety of dimensions: the military as an organization, changes in the overall scope of the military mission, and military relations with Congress. However, none of these dimensions varies across the services to any considerable extent. They are therefore not discussed any further here.

THE IMPLEMENTATION PROCESS

The third factor described in our policy implementation framework in Chapter Two is the implementation process itself. This factor includes the following dimensions: officials' commitment to statutory objectives, pressure for change, and support for change. All of these varied across the services and are therefore discussed below.

Officials' Commitment to Statutory Objectives

Officials' commitment to statutory objectives improves implementation processes and outcomes. We looked for evidence concerning the degree of official commitment and found that, although the evidence available was not overwhelming, it did point to differences across the four services.

The most direct evidence concerning the degree of official commitment to statutory objectives comes from the abstracted documents, which revealed differences in the degree to which military higher-

ups planned for and actively monitored MCCA implementation in the field. As already noted, high-ranking generals in both the Army and the Air Force took personal and active interest in the implementation of the MCCA. Our fieldwork confirmed the evidence from our abstracted data on this point.

Besides these data, we also found indirect evidence for officials' commitment to statutory objectives in the efforts made to plan and monitor implementation of the individual provisions of the MCCA. All the services made some efforts to implement the various provisions of the MCCA, but the Army and the Navy made special efforts to plan and monitor implementation early on. Abstracted Navy documents show implementation plans that present financial and end-strength goals. It should be noted, however, that these Navy documents also reveal some reluctance to embrace all of the provisions of the act, as evidenced by some documents requesting the recipients to "document the pain" associated with the implementation of the provision.

Army officials, on the other hand, were unequivocal in their commitment to the statutory objectives of the MCCA. Indeed, we found a document that contained a very detailed implementation plan, listing each MCCA requirement, DoD action, Army action, Army CDS POC, and MACOM action required to implement it. This document also showed that as early as May 1990, the Army had begun to implement a number of MCCA requirements.

The evidence concerning commitment to statutory objectives on the part of Marine Corps officials is rather negative. Neither the abstracted documents nor our fieldwork data reveal commitment to the statutory objectives on the part of Marine Corps officials. Indeed, the abstracted documents indicate that the Marine Corps actively resisted implementation of some of the MCCA's provisions, at least at the beginning of the implementation phase.

In short, available data indicate that officials' commitment to statutory objectives was greatest in the Army, least in the Marine Corps, and intermediate in the Navy and the Air Force. These differences help explain the observed differences in MCCA implementation. At the same time, individual leaders in the Air Force and Army made

major contributions to implementation outcomes, as discussed below.

Goggin (1987) argues that an organization's implementation style is an important indicator of commitment and predictor of implementation outcomes independent of other organizational characteristics. He defines four different implementation styles: (1) defiance—delay with modifications that reduce the likelihood of achieving the goals of the innovation; (2) delay—delay with no modifications; (3) strategic delay—delay with modifications that increase the likelihood of achieving the goals of the innovation; and (4) compliance—rapid or timely implementation of the innovation with or without modifications. The abstracted services headquarters documents shed some light on the issue of the services' implementation style. (See Table 12.6 for a summary of the services' early implementation style.)

The documents reveal that outright defiance was relatively rare overall. This is not surprising, given that there existed a Congressional mandate to implement the MCCA, and the documents that we abstracted were just that—documents. Outright defiance, on paper, for the record, would be a risky act, particularly in a hierarchical organization like the military. Indeed, the level of anger and defiance manifested in confidential face-to-face interviews with RAND staff was much higher than anything we saw on paper. Nevertheless, we did find some documents that express fairly straightforward defiance. Such defiance appeared most often in Marine Corps documents, which is perhaps not surprising given the more independent ethos and more daunting implementation task facing that service.

Delay was more commonly found in the abstracted materials; there are examples for each service with the exception of the Army. These documents sought rulings and interpretations from service and DoD comptrollers that would legitimize delay. Several documents directed to the field indicated that in fact delay would be tolerated—at least at the beginning of the implementation phase.

The abstracted documents also produced a few instances of strategic delay—delays with modification that increase the chances of successful implementation (Goggin, 1987). Given the nature of the MCCA, there was not a lot of room for such strategizing, but the Air

Force produced a clear example in the case of the child development career program where it managed to persuade the civilian personnel office to change the rules concerning which types of persons could be hired into caregiver positions. This delay in implementation of one of the MCCA's provisions resulted in the hiring of caregivers who wanted to do the job, an important component of quality, which was a key MCCA goal.

The abstracted documents suggest that compliance was the ultimate strategy in each service; differences are most apparent in the time until compliance became the service norm. The Army was clearly ahead of the other services in adopting a compliance strategy. To some degree, this was easiest for the Army, because some MCCA mandates had been accomplished there before the legislation's passage. Air Force documents also suggest compliance, although at a slower pace. Several Navy documents indicate strong compliance support from headquarters in the face of delayed implementation in the field. The Marine Corps appears to have moved from defiance to compliance over time.

Organizational Capacity and Financial Commitment

Organizational capacity facilitates implementation, if that capacity is engaged in an implementation effort. Seen another way, lack of capacity may undermine implementation, even when motivation exists. In the case of MCCA implementation, capacity and financial commitment tended to covary. Services committed to child development programs had been funding them before the MCCA. Consequently, these programs had more resources for MCCA implementation from the beginning. This support, in turn, reflected to some degree each service's more general capacity to support CDPs.

Perhaps the best available measure of services' organizational capacity is the APF execution rate, which indicates what percentage of the APF$ directed by the MCCA is going to child development. Table 12.6, column 2, shows the execution rate of APF$ directed by the MCCA as of March 1990. According to these data, the Army comes out clearly as most able to implement. It had executed 49 percent of funds; in sharp contrast, the Air Force had executed only 9 percent of

CDC funds.[3] The Navy ranked second to the Army, and the Marine Corps third.

Another measure of CDP capacity is the level of human resources allocated to these programs by the services. At the time of MCCA passage, the Army, which had the largest number of CDCs, had a well-staffed headquarters operation, which allowed staff to specialize in different MCCA provisions and provide expert support to the field in their respective provisions. In sharp contrast, the Marine Corps headquarters CDP office was headed up by a single individual at that time. She was soon overwhelmed by the demands imposed by the MCCA. Although Marine Corps staffing increased over time, in the crucial first months of implementation, the Marine Corps lacked crucial human capacity.

One of the most important factors influencing policy implementation is the level of financial commitment to that policy. The greater the commitment, the more likely that implementation will occur. Financial commitment is particularly important in the case of the MCCA because of its lack of appropriation, which meant that each service had to take the resources for implementation from other activities, not an easy task during a period of downsizing.

As already noted, the services varied considerably in their pre-MCCA financial commitment to child care. This variation continued throughout the implementation phase. As shown in Table 12.6, the Army shows the greatest financial commitment to child care, the Marine Corps the least, and the Air Force and the Navy were second and third. It is interesting that although no service had enough APF$ to fully implement the MCCA in FY90 because of the mid-year implementation start, only the Marine Corps described funding problems as likely to severely undermine MCCA implementation.

Given the reality of insufficient funding in the early years, it is not surprising that the services devoted much time and energy to finding ways to manage the financial burden that the MCCA imposed. Our abstracted documents reveal a number of instances in which each service questioned the status of various MCCA provisions as a means

[3]Before the MCCA, the Air Force had the lowest level of APF$ support. Thus, a good deal of change was required.

of reducing the financial burden. (See Table 12.6 for a summary of service responses to funding pressures.) In particular, the issue of whether the funding levels written into the MCCA were targets to be achieved or floors below which funding could not fall received considerable attention.

As in other respects, the four services differed in how they dealt with this issue. From the very beginning, the Army was unequivocal in its determination that funding targets were "a floor . . . not a ceiling" (Army Guidance 2/27/90). The Air Force was also relatively swift in its determination that the MCCA funding targets were to be treated as floors. A document from June 1990 states, "Clearly, it is the intent of Congress that the Air Force reach the funding levels stated in the act."

The Navy and Marine Corps dealt with the issue somewhat differently, deciding that the funding levels in the MCCA did "not create statutory floors as drafted" and that "matching parent fees with APF is a target, not a requirement." The Navy also requested that COs document the effect of loss of APF$ on other programs, such as fitness and sports programs. Such directives suggest that the Navy and Marine Corps were less financially committed to the MCCA than either the Army or the Air Force.

The documents abstracted from the Navy and Marine Corps also revealed a considerable number of mixed messages related to funding issues. One Navy message, for example, states that it "is being held accountable by Congress and the Office of the Secretary of Defense" for expanding child development services in FY90. The mixed nature of the message, "demonstrate the pain, don't blame us, we have to comply" is the sort of inconsistent message that Palumbo and Calista (1990) believe complicates implementation. Such inconsistencies were lacking in abstracted Army documents and not prevalent in Air Force documents, perhaps because of stronger financial (and other) commitments to the MCCA.

Pressure for Change

Pressure for change is directly linked with implementation outcomes. Research on regulatory policy has demonstrated that targets of mandates incur costs from complying or from avoiding compli-

ance. The choice they make to comply with the mandate or attempt to avoid doing so is based on the perceived costs of each alternative. Targets decide whether or not to comply by calculating two kinds of costs: (1) the likelihood that the policy will be strictly enforced and compliance failures will be detected, and (2) the severity of sanctions for noncompliance. If pressure for change is perceived to be high because of strict enforcement and high sanction costs, compliance is more likely (McDonnell and Elmore, 1987).

The MCCA contained significant pressure for change. The no-notice inspections and the accompanying threat of CDC closures created substantial pressure. Both our fieldwork data and the document abstraction indicated that this threat was real and significant. Another external source of pressure for change came from the prohibition against reimbursement of NAF$ with APF$ after September 30, 1991. This change was a driving force for converting child care providers funded by NAF to GS employees.

Although these pressures for change affected all the services equally, the perceived pressure for change varied considerably across services. This is particularly noticeable in the abstracted documents.

For example, a number of Air Force documents discuss the possible negative consequences of failure to implement the MCCA in a timely manner, suggesting that Air Force leaders were sensitive to implementation pressures. Indeed, they appear to have come to see successful implementation as in their own and the Air Force's self-interest, a condition that facilitates implementation (e.g., Zellman, 1996). In particular, the Air Force was worried that noncompliance might prompt Congress to pass legislation that would lessen Air Force control over the operation of and funds for child care. This concern was perhaps not unwarranted in the early phases of the implementation phase when, in addition to lagging behind on certification rate, the Air Force execution rates for both APF spending and hiring for GS positions were behind those of all the other services.

Relative to the other services, the Marine Corps seemed to perceive less pressure for change. The contents of the abstracted documents reveal only limited concern about compliance, at least in the early stages of implementation. Over time, as funds began to become available (the DoD provided a significant infusion in mid-1992), the

tone of the abstracted Marine Corps materials changes. Documents from headquarters to the field have a more assertive, let's-get-it-done tone. Nevertheless, the explicit threats of Congressional sanctions for noncompliance conveyed to the field by the Air Force and to a lesser extent by the Navy are largely absent in Marine Corps documents. The lesser pressure to comply is consistent with a culture of self-reliance. This culture was evident in more open CO resistance on Marine Corps bases. Another Marine Corps command representative told us that he opposed child care because the low fees in CDCs encourage young recruits to adopt a welfare state mentality, where making babies is no problem, because the state will take care of things. For example, a Marine Corps command representative to whom we spoke told us that he had turned down a MILCON child development center the year before because increased capacity would cost him more. Further, he said, he just could not justify a new CDC when the barracks are so inadequate.

In summary, the four services reacted to MCCA pressures for change to differing degrees. These data provide yet another piece of the explanation for differences across the services in MCCA implementation.

Support for Change

Along with pressure to comply, policy mandates should provide support for change. Key aspects of support are a system of rewards that recognize compliance efforts and room for bottom-level input into the process.

A set of rewards for any movement that supports implementation of the policy is key. The goal of these rewards is for individuals to perceive that their own self-interest lies in supporting the change. Such beliefs represent the energizing force for successful implementation of change (Mazmanian and Sabatier, 1983; Levin and Ferman, 1986).

Mirroring differences in real and perceived pressure for change are differences in the level of support for change demonstrated by each service. Evidence of such support may be found in the implementation guidance issued by each service.

All the services issued some kind of implementing guidance relatively quickly after DoD's own guidance was issued March 23, 1990. In many respects, these documents are similar. Each lists the main components of the MCCA and casts them in service-specific language. But in significant respects, the documents differ. Most notable is the high level of detail in the Army document and the clear sense of an implementation plan in the Navy one, both elements that provided guidance to MACOM and installation-level implementors.

Support for change from installation command also differed. Although implementation of MCCA requirements typically was carried out by CDP staff, installation commanders played a key role in this process because in many cases they were the decisionmakers regarding allocation of scarce APF$ to implement MCCA requirements. Clearly, the more supportive the CO, the more likely child care would be to receive the necessary resources to implement the MCCA.

Our mail survey data provide evidence about the extent to which COs supported the MCCA at the onset of implementation. Overall, 55 percent of installation commanders were reported by our child development manager respondents to have been either "supportive" or "extremely supportive," with an additional 22 percent "somewhat supportive." Although the average supportiveness rating varied across the services, the differences did not achieve a standard level of statistical significance. However, as can be seen in Table 12.7, the trend is for respondents to rate Air Force COs as the least supportive, and Army COs as the most supportive of the MCCA.

Over time, CO support for the MCCA changed considerably and to varying degrees in each of the four services. As shown in Table 12.8, the biggest increases in perceived installation CO support came in the Air Force and the Navy, the smallest in the Army and the Marine Corps. The Army result is probably due to high initial support, which remained high throughout, suggesting that in three of the four services, personnel experienced fairly high levels of support from their installation CO by the time of our survey. The lower level of change reported by Marine Corps respondents may well represent the results of limited support at the service level for the MCCA, limited efforts to support implementation, and an ethos that was more inconsistent with MCCA goals than was the case in the other services.

Table 12.7

Perceived CO Support for the MCCA at Implementation Onset, by Service

Service	Mean[a]	Frequency
Air Force	1.05	80
Army	1.47	61
Marine Corps	1.35	13
Navy	1.35	68
Mean	1.27[b]	222

SOURCE: Data from mail survey.

[a]The CO support scale was as follows: Extremely supportive = 2.5; supportive = 1.5; somewhat supportive = 0.5; not very supportive = –0.5; not at all supportive = –1.5.

[b]Mean differences between services are not significant (F-test).

Table 12.8

Perceived Changes in Level of CO Support for the MCCA over Time, by Service

Service	Mean Change[a]	No.
Air Force	1.52	69
Army	0.47	38
Marine Corps	0.88	9
Navy	1.22	40
Mean	1.15[b]	156

SOURCE: Data from mail survey.

[a]Cell entry based on measure with 2 = much more supportive and –2 = much less supportive. This scale is recoded from a survey scale that went from 1–5 to improve ease of interpretation.

[b]Means are significantly different: $p < 0.0000$ (F-test).

We asked mail survey respondents to identify those factors that they believed had contributed to changes in level of CO support for the MCCA. As shown in Table 12.9, the most frequently endorsed factor was "a new commander." This suggests that Mazmanian and Sabatier's (1981) advice to implementors to install supportive

Table 12.9

Reasons for Changes in CO Attitudes Toward the MCCA

Reason	Percentage[a]	No.
CDP requires too many resources	16	26
Saw benefits	32	52
CDP a chronic problem	13	21
Demand for child care up	30	50
Child care quality more important	59	96
Downsizing reduced resources	16	27
MCCA reduced CO flexibility	29	48
CO proud of CDP	43	70
New commander	61	100
No change	3	5
Total		164

[a]Percentages total more than 100 percent because of multiple responses.

personnel as a means of increasing the likelihood of successful implementation came to pass in the military as an unintended consequence of military policies of frequent staff rotation. Alternatively, it may be that as new COs came on board after implementation of the MCCA was under way, they were more likely to accept it as a *fait accompli*, a stance that CDP personnel recognized and interpreted as supportive, at least in comparison with what they may have seen from the CO on board at the start of the implementation process.

Second and third and close behind "new commander," mail survey respondents attributed increased CO support over time to perceptions on the part of COs that CDC quality was more important than they had previously thought, and that COs were proud of the CDP. This suggests that command support increased over time as COs became more familiar with the positive aspects of the MCCA and the changes that it was producing in CDCs.

In analyses of the reasons listed in Table 12.9 by service (not shown), what was perhaps most striking was that Marine Corps respondents were significantly more likely than respondents in other services to attribute changes in CO level of support to decreased CO flexibility under the MCCA. It seems fair to assume that this reason suggested perceived movement in a *negative* direction on the part of Marine Corps COs. This finding is consistent with what we found in both our

field data and in Marine Corps documents that we abstracted. As discussed above, Marine Corps COs were more likely to view the MCCA as an unwelcome incursion on their autonomy and limited budgets, and were supported in this stance by Marine Corps higher-ups who waged a long battle with the DoD over how little they could do.

In summary, support for change varied not only across the four services but also over time. The evidence suggests the greatest amount of support for change at the outset could be found in the Army. Over time, the amount of support increased considerably but most in the Air Force and the Marine Corps. Although the evidence presented here is both more complex and more equivocal than in previous chapters, it nonetheless sheds some light on another set of reasons for observed differences across the services in MCCA implementation.

THE LOCAL CONTEXT FOR CHANGE

The fourth and final factor described in our policy implementation framework in Chapter Two is the local context for change. Key aspects of the local context include individual leader support and level of monitoring. As discussed above, these factors distinguished the services and, we believe, explain interservice differences in implementation outcomes.

A few key individuals often make a significant contribution—positive or negative—to the implementation process. As "fixers" or "entrepreneurs" (Levin and Ferman, 1986; Bardach, 1980), such individuals work to support implementation and smooth a process that may be hitting snags.

We encountered important instances of such support in both the Air Force and Army. In the Army, an interested general caused things to happen because he wanted them to. For example, he asked FCC providers what program improvement they most wanted to see. When they said, "paid vacations," they got them, at least for a time. In the Air Force, one general's ongoing commitment to supporting CDC accreditation had visible effects on implementation outcomes: The Air Force became a leader in CDC accreditation. His chosen method of making a difference was a tried and true one: active mon-

itoring of implementation progress. He let it be known that he would personally review waiver requests, then did so. Many were rejected.

The negative case applied on several Marine Corps and Navy installations that we visited. Despite overall increases in perceived CO support over time reported by survey respondents, some COs were resolute in their opposition to the MCCA. Although personal commitment may compensate to some degree for lack of financial resources, on these bases we found limited financial support linked to personal opposition. CDP personnel on these bases were aware of these views and implementation suffered. In one instance, for example, the CDP director, who had actively worked to accredit a less than exemplary CDC, was called on the carpet for her effort, which was perceived to increase CDC costs.

SUMMARY OF INTERSERVICE DIFFERENCES

To a substantial degree, the abstracted documents paint a picture of MCCA implementation that reflects what we found in the course of our field visits to installations and in the analyses of the mail survey data. In short, the Army seemed most prepared to implement and did so more quickly and with less apparent difficulty or uncertainty than the other services. The Army's relative ease of implementation reflected greater organizational resources, i.e., amount of APF$ budgeted in FY90 for CDP. In addition, the similarity of many MCCA provisions to existing Army policies and procedures meant that the Army had fewer changes to make to implement the MCCA.

To a lesser extent, the Navy was also ahead of the MCCA implementation curve, e.g., training was already in place. At the same time, the more decentralized Navy organizational structure meant that central policies may not have filtered down to the base level, requiring more work to implement the MCCA.

The Air Force was unique in having a committed general who prodded reluctant or slow implementors and actively monitored the process over time. At the same time, the lowest level of APF$ support before the MCCA meant that much change was needed to implement MCCA provisions.

The Marine Corps began the implementation of the MCCA with few resources and a long way to go. There was no precedent in the Marine Corps for most of the MCCA provisions. Funding was limited, and headquarters staff were too few to actively monitor the implementation process. In addition, the Marine Corps was the most defiant in the face of MCCA requirements. Although later documents indicate efforts to comply, the early years of implementation were marked by lack of funds, delay, and resistance.

CONCLUSIONS

The MCCA was an unfunded mandate embodying a coherent theory of change that was to be implemented in a hierarchical, rule-driven organization. Given the nature of the policy instrument—a mandate—and its source—Congress—there was little doubt that a reasonably high level of implementation would occur.

The high degree to which the legislation structured implementation of some components, most notably a vigorous, highly public inspection program, new and required personnel categories, and improved staff salaries and training, facilitated implementation and resulted in near-total compliance with these legislative provisions throughout the DoD. In contrast, the legislation did little to structure the implementation of other components, such as the APF$ match, and implementation suffered.

Despite near-certain implementation at some level, key aspects of the policy context, especially downsizing, complicated the process. The lack of an initial appropriation further complicated the process and, by forcing the services to draw on their own resources to support implementation, magnified differences among the services in implementation experiences and outcomes. Lack of an appropriation also decreased support for the MCCA among key players, most notably Navy, Air Force, and Marine Corps installation commanders, many of whom told us that they had had to take funds for MCCA implementation "out of hide."[4] Service differences in commitment to MCCA goals further widened the gulf.

[4]Army and Air Force COs received funds from the top early on, so COs did not in fact have to take funds "out of hide."

Yet, despite services' differences in ease of implementation and in implementation status at the time of our survey, the overall picture is a positive one: The MCCA had for the most part been implemented as Congress intended. In the next chapter of the report, we analyze the effects of the MCCA.

Chapter Thirteen

MCCA OUTCOMES

The main goals of the MCCA were to increase the quantity and quality of child care on military installations and to ensure the affordability of care. In addition, the act sought to standardize the delivery and quality of care across installations and military services, which in 1989 were perceived to vary widely.

To do so, the MCCA prescribed remedies for a number of problems that characterized many parts of the system at that time, e.g., high staff turnover and inadequate facilities. The first part of this chapter describes the extent to which the problems that the MCCA addresses were perceived as such before its passage. The chapter then focuses on perceptions of the degree to which the MCCA has successfully resolved these problems. The chapter then analyzes the degree to which the main goals of the MCCA—increased availability and quality—have been met. The chapter ends with an analysis of the extent to which the MCCA changed FCC and YP.

PRE-MCCA PROBLEMS

We asked respondents to our worldwide mail survey to report on the major program problems with military child care before the MCCA to determine the extent to which these problems were resolved by the act. Table 13.1 shows the percentage of respondents who endorsed each listed problem.[1]

[1]The exact wording of the question was as follows: "Prior to the MCCA, what in your view were the major program problems with military child care?" The seven response

Table 13.1

Major Child Care Problems Pre-MCCA

Problem	Percentage[a]	Rank
Staff training	78	1
Staff retention	70	2
Lack of developmental care	53	3
Inadequate facilities	50	4
Quality of care	43	5
Unmet demand	34	6
Other problems	12	7

SOURCE: Data from mail survey.

NOTE: N = 244.

[a]Percentages sum to more than 100 because respondents could indicate more than one problem.

The most frequently endorsed problems concerned child care staff. Almost 80 percent of survey respondents indicated that staff training was a major problem before the MCCA, and 70 percent reported staff retention to be a major problem. About half of respondents indicated that lack of developmental care and inadequate facilities were a problem; 43 percent thought that overall quality of care was a concern. About one-third of the respondents indicated that unmet demand was a problem. The most frequently reported "other problems" included low pay, lack of funding, and lack of command and/or MWR support.

The most frequently reported major problems before the MCCA—staff training, staff retention, and lack of developmental care—were problems that have been found in other work to negatively affect the quality of care provided (e.g., Belsky, 1984; Ruopp et al., 1979). Reducing the prevalence and magnitude of these problems would seem to hold promise for improving the quality of care.

It is interesting to note that unmet demand was the lowest-ranked response aside from "other problems." Thus, although enormous waiting lists played an important role in persuading Congress to undertake a military child care act, this was perceived to be less of a problem among child care administrators at the installation level

categories listed in Table 13.1 were provided. In addition, there was space to write in other problems.

some three years into the implementation effort than quality-of-care concerns.

One reason why unmet demand may have been perceived by fewer respondents as a major child care problem is that in contrast to staff training or turnover, unmet demand may be less evident and may have fewer behavioral implications for the child development managers who completed our survey. A caregiver's decision to leave her job will force a CDP manager to take steps to replace her, but the addition of one or two more families to the waiting list, while troubling, may not require any response on a manager's part.

It may also be that issues of unmet demand are more likely to play out higher up in the system, where decisions are made concerning the allocation of resources to address the problem. Indeed, on 11 of the 17 installations that we visited, the command representative described unmet demand as a significant child care problem. Two other command representatives said a long-standing problem with unmet demand had recently been resolved when a new CDC opened.

When analyzing perceived problems pre-MCCA by service, some interesting results emerge. There were no significant differences in the percentage of respondents reporting that quality of care was a problem across the services, nor were there any significant differences in reported staff retention problems (results not shown). However, staff training, unmet demand, lack of developmental care, and inadequate facilities were reported to be major problems at significantly (or borderline significantly) different rates across the services. These results are reported below.[2]

Table 13.2 shows the percentage of respondents, by service, who indicated that each of the problems listed had been a major child care problem before the MCCA.

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[2]"Other problems" were reported at borderline significantly different rates across the four services. However, because of the overall low response rates for this category, these results are not shown.

Table 13.2

Major Child Care Problems Pre-MCCA, by Service (in percent)

Service	Staff Training	Staff Retention	Lack of Developmental Care	Inadequate Facilities	Quality of Care	Unmet Demand	Frequency
Air Force	89	70	63	62	52	27	88
Army	73	73	43	37	34	29	70
Marine Corps	85	62	69	62	46	31	13
Navy	70	70	48	51	38	49	73
Mean	78[a]	70	53[a]	50	43	34[b]	244

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.05$ (F-test).

[b]Means are significantly different : $p < 0.01$ (F-test).

The means for staff training were significantly different from one another. The problem of staff training was perceived to be greater in the Marine Corps and the Air Force than in the Army and the Navy pre-MCCA. This makes sense because the Navy and Army were using Navy-developed training modules before the MCCA. Or, Air Force personnel, many of whom had gone through accreditation by the time of our survey, were in a position to be more critical of past policies and procedures. The cross-service means for staff retention were not significantly different, reflecting the widespread nature of this problem before the MCCA.

The means for lack of developmental care are significantly different. That the Marine Corps and the Air Force report having more of a problem with developmental care before the MCCA than either the Navy or the Army is consistent with their higher rates of reported problems with lack of trained staff and their less developed training programs before the MCCA.

The means for inadequate facilities are significantly different at the 0.06 level, thus just barely past accepted significance levels, indicating service differences in problems with inadequate facilities. The fact that Marine Corps respondents reported the highest level of problems with inadequate facilities is consistent with the other data we collected.

The means for quality of care as a major problem pre-MCCA did not vary significantly by service. However, the means for unmet demand are significantly different, indicating that respondents from different services perceived unmet demand to be a major problem before the MCCA at varying rates. In particular, the Navy reported more of a problem with unmet demand.

PROBLEM RESOLUTION

It is interesting to examine the extent to which respondents at the installation level perceived the act to have been successful in resolving the problems that they perceived to exist before the MCCA. Table 13.3 shows the distribution of responses to this question.

It is noteworthy that 85 percent of respondents reported that many or all or almost all of the problems that existed before the MCCA were resolved by the act. Less than 3 percent indicated that none or almost none of these problems have been resolved by the MCCA.[3]

There are no significant differences across the four services in the distribution of responses to the question concerning the extent to which the MCCA has resolved existing program problems with military child care (results not shown). In other words, the MCCA was perceived as being equally effective by all the services in resolving major program problems despite initial differences in the types and prevalence of problems reported.

[3]To facilitate the interpretation of the responses to this question, it is possible to convert the response categories to percentages. This is necessarily a somewhat arbitrary exercise, but it does provide a more intuitive understanding of the overall extent to which the MCCA resolved existing problems. If the response categories 1–4 are converted to 100 percent, 67 percent, 33 percent, and 0 percent, respectively, the average amount of problems resolved is 70 percent. Alternatively, if one converts the response categories 1–4 to the midpoint of the quartile intervals (i.e., to 87.5 percent, 62.5 percent, 37.5 percent, and 12.5 percent), the average improvement reported is 65 percent. It is impossible to determine which conversion scale is better, but together, they provide a sense that respondents perceive that about two-thirds of preexisting problems have been resolved by the MCCA.

Table 13.3

Respondents' Perceptions of the Extent to Which the MCCA Resolved Existing Major Program Problems

MCCA Resolved	Percentage	Cumulative Percentage	Frequency
All or almost all	29	29	66
Many	56	85	126
A few	13	97	29
None/almost none	3	100	6
Total	101[a]		227

SOURCE: Data from mail survey.

[a]Entries do not sum to 100 because of rounding imprecision.

PRE-MCCA QUALITY OF CARE

To get a sense of the quality of care before the implementation of the MCCA, we first asked our respondents to rate the quality of care in the CDC(s) on their installations before the act. As shown in Table 13.4, before the MCCA less than 10 percent of respondents indicated that they thought the overall quality of care had been excellent; 17 percent reported that it had been not very good or not good at all. The average quality rating was 2.7, or somewhere between very good and OK/fair, but closer to OK/fair (see Table 13.5 for average quality ratings by service).

Table 13.4

CDC Quality of Care Ratings Pre-MCCA

Rating		Percentage	Cumulative Percentage	Frequency
Excellent	1	9	9	20
Very good	2	37	47	80
OK/fair	3	36	83	78
Not very good	4	12	95	25
Not good at all	5	5	100	11
Mean	2.7			
Total		99[a]		214

SOURCE: Data from mail survey.

[a]Entries do not sum to 100 because of rounding imprecision.

Table 13.5

Average CDC Quality of Care Rating Pre-MCCA, by Service

Rating	Mean	Std. Dev.	Frequency
Air Force	2.9	0.99	77
Army	2.5	0.81	60
Marine Corps	2.7	0.89	12
Navy	2.5	1.08	65
Mean	2.7[a]	0.98	214

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.06$ (F-test).

As already noted, there was a perception in Congress before the MCCA that quality of care varied substantially across installations and services. Table 13.4 indicates that across the DoD, perceived quality ratings ranged from excellent to not good at all before the MCCA. Mean quality ratings by service are shown in Table 13.5. Recalling that higher quality ratings are denoted by lower scores, this table indicates that Army and Navy respondents reported the highest level of quality of care before the MCCA. Differences across services are significant at the 0.06 level of significance (F-test).

This quality ranking by service is consistent with information we obtained during our interviews with DoD and headquarters child care staff in each military service. As discussed above, the Army and Navy had staff training programs in place before the MCCA; respondents from these services were less likely to describe staff training as a problem. In addition, the Army had T&C specs working in CDCs before the MCCA. In contrast, the Marine Corps in particular lacked staff and support to pursue improved quality of care.

It was somewhat surprising that Air Force respondents reported the lowest average pre-MCCA quality of care. Our interviews with service headquarters child care staff as well as installation visits during our earlier investigation of military child care (see Zellman, Johansen, and Meredith, 1992) did not indicate that the Air Force deserved this quality of care designation, which suggests, as noted above, that Air Force respondents may have been particularly critical because so many had undergone self-study and accreditation.

These rankings by service suggest that survey respondent ratings must be approached with care. These ratings are based on installation level child care manager perceptions. They are likely to be influenced by the respondents' ability to recognize good quality of care as well as the respondents' expectation about what the level of quality of care should be. These perceptions may be biased in unknown ways by limited experience in observing CDCs in many cases (Zellman, Johansen, and Meredith, 1992). To the extent that these two factors varied across services, this may have influenced the reported ratings of pre-MCCA quality of care. Pre-MCCA ratings, in particular, may be biased because respondents may not have been employed at the installation before the MCCA. Although respondents were encouraged to seek out the views of colleagues in cases where the respondent herself was unable to answer pre-MCCA questions, we do not know if respondents sought more reliable sources in answering pre-MCCA questions.

It is interesting to note, however, that poorer quality ratings by Air Force respondents are consistent with the responses provided to a question concerning the major problems faced by military child care before the MCCA. On a problem checklist, a higher percentage of Air Force respondents than those in the other services reported quality of care to be a problem before the MCCA (see Table 13.2, above).

QUALITY OF CARE POST-MCCA

To what extent did the MCCA improve the perceived quality of care? Table 13.6 shows the distribution of responses to a mail survey question concerning the overall quality of care at the time of our survey (mid-1993). The table is striking in that the distribution of responses has narrowed considerably in comparison to the comparable question for the pre-MCCA period. Instead of five quality ratings, there are now only three, because no one reported the quality of care to be not very good or not good at all. Furthermore, 60 percent of respondents reported the quality of care to be excellent, and only 4 percent reported the quality to be OK/fair. Thus, more than 95 percent of respondents indicated that the quality of care after the implementation of the MCCA was very good or excellent, a considerable improvement over the situation reported before the MCCA.

Table 13.6

CDC Quality of Care Ratings Post-MCCA

Rating		Percentage	Cumulative Percentage	Frequency
Excellent	1	61	61	145
Very good	2	35	96	84
OK/fair	3	4	100	10
Mean	1.4			
Total		100		239

SOURCE: Data from mail survey.

Table 13.7 shows the average post-MCCA quality rating both overall and by service. Not surprising given the results shown in Table 13.6, the average reported quality of care was higher post-MCCA (1.4), somewhere between excellent and very good, but closer to the former than the latter. Quality ratings by service border on being significantly different ($p = 0.09$), indicating that although the overall variation in reported post-MCCA quality of care has declined, differences in reported quality across services remain post-MCCA. However, although the pre-MCCA quality ratings were highest in the Army and the Navy, post-MCCA quality ratings show that Marine Corps respondents rate their quality of care post-MCCA most highly, and that Army respondents take the last position on this measure.

Table 13.7

CDC Quality-of-Care Ratings Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.4	0.52	85
Army	1.6	0.69	70
Marine Corps	1.2	0.44	13
Navy	1.4	0.52	71
Mean	1.4[a]	0.58	23

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.09$ (F-test).

This rank-ordering is inconsistent with a range of other quality indicators we collected and points up the subjective nature of the survey data. For example, the CDC accreditation rate in the Army is more than three times that of the Marine Corps (34 compared to 10 percent), and is the highest in the Air Force. Survey data on perceived changes in the level of command support for the MCCA indicate that Marine Corps respondents were significantly more likely than respondents in other services to perceive less support. This lack of command support is inconsistent with high quality.

Our installation visits also indicated that quality of care continued to be less of an issue in the Army because of greater support for child development among Army commanders. One Army CO, for example, decided to continue the quarterly developmental assessment team (DAT) meetings after MCCA implementation was largely accomplished, as they provided a means of keeping him informed of child development operations.

High-quality ratings among Marine Corps respondents that are at variance with our own perceptions and with other more objective indicators may be a function of the amount of improvement experienced—that is, respondents were noting *relative* change. In other words, current quality ratings may reflect substantial change as much as high current quality. In contrast, high-quality care of long standing that is somewhat or only slightly improved may suffer by comparison. To test this hypothesis, we investigated both the absolute amount of perceived quality improvement after the MCCA (see Tables 13.8 and 13.9)[4] as well as the relative amount of reported change (see Table 13.10).

Table 13.8 shows that about 70 percent of survey respondents indicated that the quality of CDCs on their installation had improved by one or two quality rating categories after the MCCA. Twenty percent of respondents indicated no improvement, and one respondent actually reported a decline in quality of care after the MCCA.

[4]Table 13.8 was created by subtracting the pre-MCCA quality rating from the post-MCCA quality rating. As a higher-quality rating results in a lower score, a quality improvement would result in negative score. The minus sign has been suppressed in Tables 13.8 and 13.9 to improve the interpretability of the tables.

Table 13.8

Absolute Quality Improvement Scores Pre-Post-MCCA

Quality Score Improvement	Percentage	Cumulative Percentage	Frequency
−1	0	0	1
0	20	20	42
1	46	66	96
2	24	90	50
3	9	99	18
4	1	100	3
Total	100		210

SOURCE: Data from mail survey.

Table 13.9

Average Quality Improvement Scores Pre-Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.5	0.98	75
Army	1.0	0.82	60
Marine Corps	1.4	1.00	12
Navy	1.1	0.91	63
Mean	1.2[a]	0.93	210

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.01$ (F-test).

Table 13.10

Relative Improvement in Quality of Care Rating, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	48	23	75
Army	36	26	60
Marine Corps	49	21	12
Navy	38	25	63
Mean	41[a]	25	210

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.01$ (F-test).

Looking at the average reported quality improvements in Table 13.9, we see that overall, average reported quality improvement is 1.2 response categories. Perhaps not surprisingly, Army respondents reported the least absolute quality improvement, and Air Force respondents reported the most.

Relative to their pre-MCCA quality rating, Marine Corps and Navy respondents reported the greatest improvement (see Table 13.10),[5] suggesting that the Marine Corps' high ranking in Table 13.7 does reflect substantial change.

Overall, the average reported quality ratings improved by 41 percent.[6] This tremendous increase in perceived quality of care as a result of the MCCA was widely echoed in our installation interviews as well as at the headquarters level in each service and at the DoD. Everywhere we went we heard the same message: care had improved substantially, sometimes dramatically, as a result of the MCCA.

For example, a Navy MWR director noted that the MCCA had increased staff quality and professionalism and had resulted in "tremendous improvement" in how care in CDCs is delivered. An Air Force CO concurred, noting that higher pay has attracted better-quality staff, which has led to significant improvements in the delivery of care. At another Air Force base, the MWR director told us that in his view, the MCCA has made military child care the best in the world. Said his counterpart at another Air Force base, "despite groans and grunts, it [the MCCA] has given us a quality program."

A Marine Corps garrison commander agreed that, since the MCCA, children are "better developed," but this has come at a price: "Quality is up," he said, "but quantity is down." Even those who were not supportive of the MCCA acknowledged that such provisions as increased caregiver wages and more rigorous training had improved the quality of care. There was less consensus about whether improvement had been needed: At one Marine Corps base that we

[5]As in the case of Table 13.8, the negative sign on the reported quality improvement has been suppressed to improve the interpretability of the results.

[6]Dividing the results in Table 13.5 by the results in Table 13.8 does not yield the identical results reported in Table 13.9 because of missing values on a number of respondents in Table 13.5.

visited, both the CO and comptroller agreed that quality had increased, but the CO thought it had been OK before, whereas the comptroller described the level of pre-MCCA quality as "warehousing."

In a few instances, RAND had visited the same CDC before the MCCA during our previous study (see Zellman, Johansen, and Meredith, 1992, for a report of study findings), thus we were able to see the tremendous improvements ourselves. In a few cases, CDCs that had had major problems with the quality of care had become accredited. The difference was tremendous; a number of things were visibly changed, e.g., the amount and type of resources, the interaction between the children and between the children and the caregivers, and the pride exuded by the caregivers and the staff.

In places that we had not previously visited, we heard repeatedly how much quality had improved as a result of the MCCA. Even at the CDCs that were known to have been providing good quality care before the MCCA, we were told of improvements. However, the greatest improvements were generally reported on those installations that had had the worst quality of care before the act. Repeatedly, we heard that the act's threat of center closure in case of a failed inspection provided the clout to obtain resources needed to improve quality.

A high-level headquarters interviewee was clear on this point. The inspections definitely resulted in increased command attention; "no commander wants an unsatisfactory rating," she said. Even in the services that had had inspections before the MCCA, inspections with teeth were reported to be a benefit, because inspections without the threat of center closure had not motivated command to fix identified deficiencies. The increased visibility of the inspection report—communicated during an outbriefing with the commander—also helped create pressure to obtain necessary improvements.

In addition, the establishment of a T&C spec position, also a provision of the MCCA, helped achieve improvements in the actual provision of services to children. Thus, quality of care improved because of two of the MCCA's major provisions: inspections and the hiring of T&Cs specs.

DECREASED VARIABILITY IN QUALITY OF CARE

In addition to information regarding variations in quality of care across services, we also investigated the effect of the MCCA on variations in quality of care across the CDCs on a single installation. Specifically, we asked our mail survey respondents on installations with more than one CDC to indicate the extent of variation that they perceived in quality of care across CDCs before and after the MCCA. The results concerning pre-MCCA variation in quality of care are shown in Tables 13.11 and 13.12.

According to our respondents, variation in quality of care across CDCs on their installation was minimal before the MCCA. Almost 40 percent reported little or no variation in pre-MCCA quality of care.

Table 13.11

Variations in Pre-MCCA Quality of Care Across CDCs on an Installation

Amount of Variation		Percentage	Cumulative Percentage	Frequency
No variation	0	26	26	29
A little variation	1	14	40	16
Some variation	2	42	81	47
A lot of variation	3	19	100	21
Mean		19		21

SOURCE: Data from mail survey.

Table 13.12

Variations in Pre-MCCA Quality of Care Across CDCs on an Installation, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.8	0.98	40
Army	1.5	1.02	39
Marine Corps	1.8	1.17	6
Navy	1.1	1.13	28
Total	1.5[a]	1.07	113

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.04$ (F-test).

The average amount of variation reported is "1.5," or somewhere between a little and some variation.

However, during fieldwork we encountered a few installations with multiple CDCs where quality varied substantially. On one of these installations, the child development coordinator had decided to address the issue of unequal quality by accrediting the least-ready center first. By so doing, she would be dramatically improving quality in the least capable center and would also be sending a message to the other centers that accreditation should be fairly readily achievable for them.

In contrast, on another fieldwork installation with acknowledged quality variation between the two CDCs, the child development coordinator accredited both centers together. She knew that the process would have been easier if she had gone with the more-capable center first, she told us, but she worried that accreditation of the higher-quality newer center would make parents even less happy with the older one.[7] Both centers were successful on the first try.

Although there was not much reported variation on installations in pre-MCCA quality of care overall, there were significant differences ($p = 0.04$) in this measure by service. As can be seen in Table 13.12, Marine Corps and Air Force respondents reported greater variation in quality of care among CDCs on the same installation before the MCCA.

Table 13.13 shows the amount of post-MCCA variation in perceived quality of care across installation CDCs. Almost 85 percent of all respondents report a little or no variation in the quality of care among the CDCs on their installation. This is more than twice the proportion of respondents reporting a little or no variation in quality of care at the installation level pre-MCCA. Similarly, the average reported variation in quality of care after the MCCA declined by more than 50 percent to 0.73, or somewhere between no variation and a little variation. It is interesting that although there were significant differences across the four services in the average amount of reported quality variation among CDCs on an installation pre-

[7]In fact, the Air Force required that all centers on an installation be accredited at the same time to ensure improved quality for all children in care on the installation.

Table 13.13

Variation in Post-MCCA Quality of Care at the Installation Level

Amount of Variation		Percentage	Cumulative Percentage	Frequency
No variation	0	45	45	58
A little variation	1	39	84	50
Some variation	2	12	97	16
A lot of variation	3	3	100	4
Total		99[a]		128

SOURCE: Data from mail survey.

[a]Entries do not sum to 100 because of rounding imprecision.

MCCA, there are no significant differences in the average amount of reported variation in post-MCCA quality of care (results not shown).

To better understand the reduced variation in post-MCCA quality of care across CDCs on a single installation that we found, we analyzed whether the reduction was related to the amount of quality improvement that respondents indicated had occurred. Table 13.14 shows the average reduction in variation in quality of care by the total amount of reported quality improvement.[8]

Table 13.14

Reduction in Variations in Quality of Care at the Installation Level

Quality Improvement	Mean	Std. Dev.	Frequency
0	0.39	0.72	23
1	0.90	0.94	41
2	0.94	0.97	17
3	1.67	0.87	9
Mean	0.86[a]	0.94	90

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.004$ (F-test).

[8]Improvements in quality of care are reported as positive to aid the interpretation of the table. Thus, a higher number corresponds to a higher reported level of improvement in quality of care; similarly for the reductions in variation of quality of care at the installation level.

There is indeed a striking relationship between rated overall improvement in quality of care and reduction in variation in quality of care across CDCs on a single installation. The greater the amount of quality improvement that respondents perceived, the less the amount of quality variation across CDCs on a single installation that they reported.

EXPLAINING IMPROVED QUALITY

What explains the greater quality that we and others observed?[9] Several things stand out. First, many of the mechanisms that would increase quality were built into the MCCA as provisions of the mandate. Thus, there was no need to debate *how* to make quality happen. As our model suggests, the high degree to which the MCCA structured implementation of key quality-related provisions contributed substantially to improved quality outcomes. The required APF$ match, an inspection program that defined success and specified public consequences for failure, a hot line that enabled the DoD to learn of substandard CDCs, and the wage increase tied to training milestones set in place the means and mechanisms to bring about higher-quality programs and to monitor the improvement process. The accreditation demonstration program contributed as well to improved quality standards and also precipitated accreditation mandates in the Army and Air Force.[10] In addition, mechanisms that recognized the way in which the military works, such as the CO outbrief at the end of the inspection process, ensured that information about quality reached those who had a stake in its presence.

For the most part, the wage increases, training requirements, and inspection system overcame what was missing in the MCCA—an initial allocation of financial resources, adequate planning time and, in some services, a strong consensus as to the value of the new policy to the organization.

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[9]We were able to observe quality improvements firsthand in some of those CDCs to which we returned during this portion of the study.

[10]The Navy and Marine Corps have also adopted universal accreditation policies since the end of our data collection period.

An inspection process in which DoD personnel were active players was particularly powerful in ensuring compliance with the MCCA's provisions. In the first round of inspections, a Marine Corps CDC was closed. This action caused shock waves that reverberated far beyond the Marine Corps. Reluctant implementors everywhere understood that compliance failures (or at least those concerned with safety and ratios) would be noticed and publicly sanctioned.

The message was heard. As discussed above, our survey data indicate that differences in perceived quality across services before MCCA implementation narrowed considerably by the time of our survey. Improvements in average quality rating by service from before the MCCA to the time of our survey were significantly different from one another, with Army respondents, not surprisingly, reporting the least pre-post improvement, and Air Force and Marine Corps respondents reporting the most. Indeed, Marine Corps respondents experienced so much improvement that their post-MCCA quality ratings were the highest of the four services.

The absence of an initial appropriation and adequate planning time did, however, matter, and was particularly significant in those services and on those installations with limited capacity and less commitment to child development programs. Indeed, more than one command representative told us that without funds, certain quality improvements mandated by the MCCA were not made.

A range of quality indicators such as percentage of accredited centers demonstrate that improved quality was not easily or uniformly achieved even a year after our survey. Increased capacity and commitment pre-MCCA led both the Army and the Air Force to mandate universal accreditation of CDCs, although in different ways. The Air Force's accreditation deadline led to a very high rate—86 percent accreditation by October 1994. The absence of a deadline in the Army's accreditation mandate led to a 34 percent rate; a rate considerably higher than the Navy's 19 percent and the Marine Corps' 10 percent.

At the same time, lack of funds, lack of support, and an overwhelming implementation task led many to essentially ignore some of the optional provisions, particularly FCC subsidies. In many respects, this behavior seemed rational; there was only so much that could be done immediately. But the choice to ignore these provisions rather

than some others also reflected both the enforcement process and the validity of the causal theory implicit in the MCCA.

EXPLAINING DECREASED VARIABILITY

A substantial part of Congress' concern about child care quality was founded on the enormous variability that existed in 1989 in CDCs within and across services: Congress' intent was that the more rigorous quality standards required in the MCCA would reduce this variability.

Our data indicate that for the most part, variability in quality did decline. As discussed above, nearly all survey respondents (85 percent) told us that many, almost all, or all of the major program problems that existed before the MCCA had been resolved by the time of our survey. Our data also show that in those services with the lowest pre-MCCA quality, survey respondents reported the most pre-post MCCA quality improvement, suggesting that variability declined across services. Finally, survey respondents indicated that variations in quality across the (multiple) CDCs on their installation had declined since MCCA implementation. More than twice as many survey respondents indicated that there was little or no quality variation across CDCs post-MCCA as had perceived this before MCCA implementation.

EFFECT OF MCCA ON AVAILABILITY OF CARE

One major goal of the MCCA was to increase the number of military child care slots to alleviate the excess demand reported by all the services before the act. The MCCA itself did not specify whether the intent was to increase availability of all types of child care (i.e., full-time, part-time hourly care), or only full-time care. Implementing Guidance put out by the DoD soon after the passage of the act (March 23, 1990) did not raise this issue either.

But the lack of such language in the act or initial guidance did not mean that the issue was ignored. Indeed, the Inspector General's report on military child care, which came out in the summer of 1989, had been critical of the DoD for the lack of priorities and goals in the child care program. As is standard procedure, the DoD had to re-

spond to the criticism and did so by describing as a priority those children whose parent or parents work full-time outside the home. This priority was justified by the substantial amounts of taxpayer funds going to child care.

The services also addressed this issue. The Army, in an undated Point Paper on Installation Child Care Availability Plan, states, "Full-day care should be maximized. A minimum of 75 percent of the CDC space will be designated for full-day care on installations with a full-day waiting list in excess of 30 days."

The Navy, in its plan to address unmet demand, notes that the goal of the plan is to meet the needs of working parents, a phrase that is understood to focus concern on full-day care.

The new Department of Defense Instruction (DoDI) on Child Development Programs (CDPs), published on January 19, 1993, made clear the DoD's position with regard to increased availability of care: It is full-time care that is to be encouraged. Indeed, the 1993 DoDI states, "The purpose of CDPs offered by the DoD Components is to assist DoD military and civilian personnel in balancing the competing demands of family life and the economic viability of the family unit" (p. 2).

This purpose, in mentioning economic viability of the family unit, clearly focused the effort on those families where both parents or a single parent work outside the home. The DoDI goes on to make this point even more clearly in discussing priorities for receipt of child care: "In all cases, first priority shall be given to children of active-duty military and DoD civilian personnel who are either single parents, or whose spouse is employed on a full-time basis outside the home or is a military member on active duty" (p. 2).

The DoDI underscores the focus on full-day care by further noting that "whenever possible, the DoD components will support the needs of their personnel for hourly care and preschool programs by expanding the use of facilities and programs other than the Child Development Centers (CDCs)" (p. 2).

Increasing the number of full-day care slots presented a major challenge to child care managers and command. Some of the very requirements designed to improve quality, such as stricter monitoring

of child-to-caregiver ratios, caused availability to decline. In addition, mechanisms that would ensure increases in quantity were not written into the act or the regulations, as they were for the improvement of quality. Nor was it nearly as clear what those mechanisms might be. Indeed, some of the ways in which capacity might be increased, such as MILCON construction projects, were specifically rejected by some COs in reaction to other MCCA requirements, particularly the APF$ match. Numerous COs told us that they understood that under the MCCA, each CDC slot now incurred a funding commitment. Consequently, they considered fewer, rather than more CDC slots to be desirable.

Many COs did recognize that there were other ways to increase availability, mainly through increased use of FCC. These slots, which were considered by many COs before the MCCA to impose unacceptable costs in the form of child abuse risk and monitoring of providers without hope of revenue generation, were now seen as a far less costly way to generate care than through the development of additional CDC capacity.

We asked our mail survey respondents about the effect of the MCCA on the total number of full-time spaces available in the CDCs. Table 13.15 indicates that about 20 percent reported substantially or a few less CDC spaces, whereas about 40 percent reported no change, and the remaining 40 percent reported either a few or substantially more full-time spaces in the CDC as a result of the MCCA.

Table 13.15

Changes in the Number of Full-Time CDC Spaces Post-MCCA

Amount of Change		Percentage	Cumulative Percentage	Frequency
Substantially fewer	–2	5	5	12
A few less	–1	15	20	34
No change	0	39	59	91
A few more	1	22	81	52
Substantially more	2	19	100	43
Total		100		232

SOURCE: Data from mail survey.

Although about 60 percent of the respondents report no change or a reduction in the number of full-time CDC spaces, on average, there has been a slight *increase* in the number of full-time spaces, according to survey respondents (see Table 13.16). It is interesting to note that there are significant differences by service in the average perceived change in the number of full-time CDC spaces after the MCCA. With the exception of the Marine Corps, respondents in each service reported a net increase in the number of full-time spaces in CDCs. Army respondents reported the greatest average increase. The Marine Corps results are understandable given pre-MCCA regulations, which allowed staff-to-child ratios to exceed scheduled ratios by 50 percent. Consequently, we would expect Marine Corps availability to decline under stricter enforcement of existing regulations.

Table 13.16

Average Change in the Number of Full-Time CDC Spaces Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	0.30	1.25	84
Army	0.63	0.90	64
Marine Corps	–0.38	1.26	13
Navy	0.28	0.97	71
Mean	0.34[a]	1.10	232

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.02$ (F-test).

EXPLAINING INCREASED AVAILABILITY

This second major MCCA goal was more difficult to achieve in several respects. First, unlike the quality goal, the legislation did not structure an implementation process or specific provisions that, once complied with, would increase the quantity of child care. Indeed, the contrary was the case.

Additionally, there was little compliance-monitoring with regard to quantity. Required inspections—the most public compliance indicator—do not address the issue. Nor has quantity been the focus of documents emanating from major commands, headquarters, or the DoD. The MCCA also made CDC slots more costly because of the re-

quired APF$ match. Thus, the legislation made one of its key goals *less* appealing and more difficult to attain.

Yet, these same provisions increased the appeal of additional FCC slots. As discussed above, these slots required no APF$ match and could be created quickly. In addition, an FCC monitor, now a GS employee (thanks to another MCCA provision), was overseeing FCC quality, which reduced the risks of FCC in the view of many command staff.

As our data indicate, some installations embarked on organized efforts to create additional FCC slots after the MCCA, including the relocation of the most costly infant slots out of CDCs. Overall, almost one-third of mail survey respondents indicated that the number of FCC slots had increased as a result of the MCCA; only 10 percent reported a decrease.

OTHER CDC EFFECTS

A number of other changes took place in CDCs as a result of the MCCA. We asked our mail survey respondents to indicate which changes had occurred on their installations. The results are reported in Table 13.17.

Table 13.17

MCCA-Precipitated Changes in the Provision of CDC Services

Changes in Provision of Services	Frequency	Percentage	Rank
Reduced hourly care availability	135	59	1
Moved school-age care to YP	102	44	2
Reduced hours of operation	81	35	3
Reduced infant care availability	47	20	4
Moved preschool out of CDC	45	20	5
Moved hourly care out of CDC	44	19	6
No change	31	13	7
Centralized hourly care in one CDC	28	12	8
Other change	20	9	9
Moved infants out of CDC	17	7	10[a]
Relocated school-aged care to FCC	17	7	11[a]
Total	230		

SOURCE: Data from mail survey.

[a]Tied ranking.

The most frequently reported change, reported by almost 60 percent of the respondents, was a reduction in the availability of hourly care, that is, fewer slots devoted to care for children who use care on an occasional basis. Loss of such care has been a source of concern since the MCCA's inception. These concerns led to the mounting of a DoD survey of responses to hourly care requests made to child development programs between June 12 and July 11, 1995, in a small number of locations. Preliminary findings reveal that 96 percent of those who requested hourly care during the survey period were offered such care and used it. Among the small percentage who requested but did not use hourly care, about half turned down an available hourly care slot, usually because the requestor did not want care in an FCC home. Only 3 percent of those requesting hourly care indicated that they needed such care to fulfill a volunteer commitment. The survey will be fielded again during the winter to ensure that results are not seasonally biased. They do suggest, however, that there is enough hourly care provided within the system to meet the need.

The second most frequently reported change in provision of services was a change in the location of care for school-age children, which 44 percent of respondents reported moving to YP; 7 percent reported moving it to FCC. The third most frequently reported change was a reduction in CDC hours of operation, which just over one-third of respondents indicated had taken place. About 20 percent of respondents reported that the availability of infant care in CDCs had been reduced, whereas 7 percent indicated that infant care had been moved out of CDCs. About 20 percent of respondents reported that preschool and hourly care had been moved out of CDC. Only about 13 percent reported that no change had occurred in the provision of child care services in installation CDCs as a result of the MCCA.

In addition to these changes, about 9 percent indicated that additional (or different) changes had occurred. These included both reductions and increases in services, although there were considerably more of the former. Reductions included fewer hours of operation, elimination of a half-day program, and reduced infant and toddler

care. Service increases included increased hours of service and increased numbers of full-day slots.[11]

We heard a good deal about CDC changes during our fieldwork visits as well. For the most part, respondents reported that changes were designed to increase the number of full-day care slots. Thus, they focused on moving part-day and after-school programs elsewhere and in some cases on moving infants' spaces to FCC. Fieldwork interviewees who had done the latter considered moving infant care out of CDCs as a fiscally prudent policy given higher costs for infant care and the inability to raise fees accordingly. In most instances of such movement, an active FCC recruitment program preceded the move, so that displaced infants continued to receive care.

Table 13.18 shows the percentage of respondents in each service who indicated that they had made each type of change discussed above. Almost 60 percent of all respondents indicated that they had reduced the availability of hourly care in response to the MCCA, but Air Force

Table 13.18

Percentage of Respondents Reporting CDC Changes Noted, by Service

Changes Noted	Air Force	Army	Marine Corps	Navy
Reduced hourly care	79	49	54	43[a]
Programs moved to YP	65	30	15	37[a]
Reduced CDC hours	64	20	46	11[a]
Reduced infant care	29	0	69	19[a]
Moved preschool out of CDC	29	11	8	17[a]
Moved hourly care out of CDC	13	20	31	24
Centralized hourly care in one CDC	7	25	31	4
Moved infants out of CDC	13	7	0	3
Relocated school-age care to CDC	10	7	8	4
No.	86	61	13	70

SOURCE: Data from mail survey.

[a]Means are significantly different: $p > 0.0002$ (F-test).

[11]Our fieldwork indicated that an increased number of full-day slots was usually the result of the changes described by respondents in this question. We suspect that increased numbers of full-day slots was not written in more often because it was the outcome of the many other changes described.

respondents reported doing so in much greater numbers than respondents in the other services.[12]

The second most frequently reported change—moving school-age child care programs to youth programs—also varied significantly across the services. In this case, Air Force respondents were the most likely to have reported this change and the Marine Corps the least likely, with the Army and the Navy in the middle.

Again, the Air Force was significantly more likely to report having reduced hours of CDC operation than the other services, followed by the Marine Corps.

It is interesting to note the huge variation in responses across the four services concerning reductions in infant care. None of the Army respondents reported cutting back on the availability of infant care in CDCs, whereas more than two-thirds of all Marine Corps respondents reported reducing such care.

Although the absolute differences in the proportion of respondents indicating that they had moved preschool programs out of the CDCs are small, they are still significantly different from one another ($p < 0.03$). Again, Air Force respondents are most likely to report that preschool programs were moved out of CDCs; Marine Corps respondents were least likely to report that this had occurred.

In contrast, the proportion of respondents who reported that hourly care moved out of CDCs in response to the MCCA does not vary significantly by service. It is interesting to note that Army respondents, who were least likely to report reduced hourly care availability in response to the MCCA, are most likely, after the MCCA, to report centralizing hourly care in one CDC. Marine Corps respondents are most likely to report having reduced hourly care and centralizing the remaining hourly care in one CDC. Thus, survey data indicate that the provision of hourly care was both reduced in scope and tended to be centralized on installations after the MCCA.

[12]The Air Force limits the percentage of spaces that may be used for hourly care as a matter of policy. This decision implements DoD policy to give priority to employed parents.

We found differences by service in the proportion of respondents reporting no changes to CDCs. As shown in Table 13.19, respondents in the Army and Navy, which had a leg up on MCCA implementation, were most likely to indicate that they had not made changes to CDCs in response to the MCCA.

Finally, we looked at the total number of changes made to CDCs. As Table 13.20 indicates, respondents reported on average just over two changes in the provision of CDC services in response to the MCCA. The greatest number of changes were reported by Air Force and Marine Corps respondents, which is consistent with the quality-of-care results, which indicated that the Air Force and the Marine Corps reported the most improvement in quality of care as a result of the MCCA.

Table 13.19

Percentage of Respondents Reporting No CDC Changes, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	3	0.18	86
Army	20	0.40	61
Marine Corps	8	0.28	13
Navy	21	0.41	70
Mean	13[a]	0.34	230

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.003$ (F-test).

Table 13.20

Average Number of Changes in the Provision of CDC Services, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	3.2	1.6	86
Army	1.8	1.4	61
Marine Corps	2.8	1.6	13
Navy	1.7	1.3	70
Mean	2.3[a]	1.6	230

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.0001$ (F-test).

EFFECTS ON FCC

Although FCC was paid scant attention in the MCCA or the regulations, MCCA-precipitated changes in FCC were expected because of the changes required in CDCs. In particular, decreased CDC capacity and increased APF$ attached to each CDC slot made FCC slots far more appealing to command than they had been in the past. Indeed, one Marine Corps CO described FCC as "our salvation."

We asked our mail survey respondents about the effect of the MCCA on the total number of full-time FCC spaces. As shown in Table 13.21, on average, there was a slight increase in the number of FCC spaces, as the overall mean was 0.34. About 10 percent of respondents reported a decline in the number of full-time FCC slots, almost 60 percent reported no change, and the remaining 30 percent reported an increase in the number of full-time FCC spaces. There were no significant differences by service in reported changes in the number of full-time FCC spaces.

But changes to FCC were not limited to availability of slots. A critical change that has helped to more closely integrate FCC into the child development system was the establishment of the FCC coordinator position as a GS position in response to the MCCA. This competitive service position has provided increased legitimacy and stability to the FCC program on many installations. One FCC coordinator

Table 13.21

Changes in the Number of Full-Time FCC Spaces

Amount of Change		Percentage	Cumulative Percentage	Frequency
Substantially fewer	−2	4	4	8
A few less	−1	7	11	14
No change	0	57	67	118
A few more	1	17	84	35
Substantially more	2	16	100[a]	33
Mean		34		
Total		101[a]		208

SOURCE: Data from mail survey.

[a]Percentages may not sum to 100 due to rounding imprecision.

told us that the new GS coordinator position has brought FCC into the mainstream of child care on her Navy base. As a result, FCC providers now see themselves as more professional; they provide child care, not just babysitting. This increased professionalization was noted elsewhere as well. However, one FCC coordinator told us that the professionalization came at a price: Some of her older providers decided to quit rather than undergo the increased training now required of FCC providers by the Army. As was true for some CDC directors, this coordinator rued the loss of these grandmotherly types, and wondered if the system ultimately benefited from the imposition of stricter training requirements. However, most FCC coordinators to whom we spoke believed that the increased training requirements had been a boon to FCC.

The FCC coordinator position has also allowed for increased recruiting of FCC providers. On one Marine Corps base, monthly articles in the local paper, talks at the predeployment session given by the Family Support Center, and an FCC newsletter—all things that were not possible before there was an FCC coordinator position—have helped to substantially expand the program, from four homes to 16 in a short period of time.

The inclusion of the FCC program in the MCCA-required inspections and certification process has also brought the FCC program more into the child development mainstream. Child development managers now ignore FCC at their peril; problems in that program could deny them certification. Consequently, the program has received more attention, and the attention has resulted in program improvements.

Better training for FCC providers, more frequent and rigorous inspections, and, in the case of the Army, designated FCC T&C specs and IEPs for each FCC caregiver that track her training, all help to legitimize FCC and reduce concerns about its inherent liabilities.

Our survey attempted to assess the extent of these changes. We asked respondents who had an FCC program on their installation if there had been any changes in the FCC program in response to the MCCA. As shown in Table 13.22, most respondents indicated that their FCC program had indeed changed.

Table 13.22

Changes in the FCC Program in Response to the MCCA, by Service

Service	Percentage	No.
Air Force	86	85
Army	75	57
Marine Corps	83	12
Navy	48	52
Mean	73[a]	206

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

Those who indicated that changes had occurred to their FCC program were asked to describe those changes. As shown in Table 13.23, changes were identified throughout the program, although respondents most often identified changes in the amount and quality of provider training. Indeed, the widespread nature of these changes is quite dramatic, given the limited attention to FCC in the MCCA. One reason for the widespread nature of the changes is that in some cases, these changes were required in policies that followed from the MCCA. For example, the Army chose to require that there be a separate T&C spec for the FCC program. The presence of an FTE responsible for training would be likely to increase both its quantity and quality. The relatively low numbers for the Army in Table 13.23 probably reflect the Army's greater emphasis on FCC before the MCCA; for example, provider IEPs were already required when the MCCA passed. In addition, some of the changes that the Army made may not be reflected in the categories that we provided respondents on the survey form.

In addition, the Army required that the amount of training that FCC providers receive be the same as that required of CDC caregivers. Army respondents were unanimous in describing this change as the critical difference in the improved quality of the FCC program. Provision of identical training also allows FCC providers to fairly easily become CDC caregivers.

A few Marine Corps respondents attributed an energized and expanded FCC program to a realization on the part of some COs that the MCCA's APF$ match requirement meant that each CDC slot

Table 13.23

Changes to FCC Program Noted, by Service (percent)

Service	Increased No. of Providers	Lower Ratio of Providers to Monitors	More Provider Training	Better Provider Training	Moved Infant Care to FCC	Moved After-School Care to FCC	No.
Air Force	33	20	67	67	16	3	88
Army	10	3	38	45	4	1	69
Marine Corps	54	8	69	69	8	0	13
Navy	19	4	25	28	4	3	72
Total	24[a]	10[a]	46[a]	49[a]	9[b]	2	242

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

[b]Means are significantly different: $p < 0.05$ (F-test).

would now cost even more. Evidence that the expansion was quality-focused may be found in the data showing widespread increases in the amount and quality of FCC provider training in both the Marine Corps and Air Force.

On one Air Force base, we were told that FCC homes are more frequently inspected since the MCCA. Before the MCCA, homes were inspected quarterly; now, inspections occur monthly, on a no-notice basis. Marine Corps respondents told us that FCC inspections became part of a newly energized inspection program that was fueled by MCCA requirements.

The findings in Table 13.23 were substantiated by our fieldwork data. Respondents in many places told us that the quantity of FCC training had increased and the quality of this training had improved. Several respondents pointed to the T&C spec position as a major factor in an improved FCC program. The T&C spec was knowledgeable about child development and would often serve as a resource to the FCC program, even when the CDC was her primary focus. Some fieldwork interviewees attributed the changes in FCC training to an increased focus on the issue of training that was part of the pay banding program. A few noted that improved CDC training curricula were made available to FCC. FCC providers in a number of places

were now eligible for and were taking joint training with CDC staff. A few FCC directors told us that their own personal goal was to make FCC training comparable to that provided by CDCs.[13]

As shown in Table 13.24, comparability of training between FCC providers and CDC caregivers varied significantly by service. As one might expect given its explicit policy on this issue, Army respondents were most likely to indicate that an FCC provider would require no additional training to become a CDC caregiver. The mean Army response was between "none" and "part." Air Force respondents indicated the greatest amount of additional training required.

Given the higher level of parity in the Army between CDC caregiver and FCC provider training, it is not surprising that Army survey respondents were most likely to describe the amount of FCC provider training as adequate to enable them to deliver high-quality care.

Table 13.24

Average Amount of Additional Training Necessary for FCC Providers to Become CDC Caregivers, by Service

Service	Mean Rating[a]	Frequency
Air Force	2.45	83
Army	1.58	57
Marine Corps	2.25	12
Navy	2.36	53
Mean	2.17[b]	205

SOURCE: Data from mail survey.

[a]1 = no extra training; 2 = part; 3 = all of CDC caregiver training.

[b]Means are significantly different: $p < 0.0000$ (F-test).

[13]FCC training modules are now available DoD-wide. They teach the same 13 competencies as the CDC modules but focus on FCC issues.

EXPLAINING EFFECTS ON FCC

The fact that the changes in the CDCs brought about by the MCCA caused some changes in FCC is not surprising, even though FCC was not much addressed in the legislation or regulations. As discussed above, decreased capacity in some CDC facilities because of stepped-up inspections and increased APF$ attached to each CDC slot made FCC slots much more appealing to command than they had been in the past. In addition, FCC slots could be created in a fraction of the time that it would take to create new slots in a new or remodeled CDC.

But other aspects of the MCCA also increased the attention paid to FCC and contributed to improved quality in that program. Probably the major change of this type was APF$ support for the FCC monitor position. As a GS position, the FCC monitor position became a more stable job and a more desirable one. It gave FCC enhanced status and, because of the stability of the position, allowed the FCC coordinator to plan training and other improvements with some sense that she would be around to carry them through.

Our findings suggest that FCC and children have benefited from new DoD policy. More provider training, more oversight, and, in limited instances, the use of subsidies have contributed to improved quality of care and greater provider professionalism.

In many ways, the military stands to benefit from more use of FCC as well. As noted above, FCC slots can be created far more quickly and cheaply than those in CDCs, a key advantage. In addition, FCC has the potential to provide care that may have a substantial effect on readiness: late-night, weekend, and sick child care. Thus, a vitalized and more professional FCC program may benefit all child care constituencies.

EFFECT ON YOUTH PROGRAMS

Although the MCCA was to apply to children from birth to 12 years of age, virtually all provisions of the act referred to those who were younger than school-age and, as noted above, nearly all dealt with those receiving care in CDCs. Because of our interest in a child development system and the DoD's concerns about youth programs,

we expanded our exploration of the implementation of the MCCA to include its possible effects on youth programs. Any effects on youth programs would be an unintentional consequence of MCCA implementation, thus we did not expect widespread change. Yet we felt that exploring MCCA effects on YP might help to clarify both MCCA implementation and the potential and problems facing the military in creating a child development system that spans the period from birth to pre-adolescence.

We asked survey respondents who had a YP on their installation to tell us if there were any changes to that program in response to the MCCA. As shown in Table 13.25, a fairly substantial percentage of respondents who had youth programs indicated that there had indeed been changes.

We asked those respondents who indicated that their installation's YP had changed in response to the MCCA to describe the nature and extent of those changes. We provided three options based on our early fieldwork visits: relocation of the before- and after-school program to YP, transfer of the administration of the before- and after-school program to YP from child development, and YP staff departures for now-better-paying CDC caregiver jobs. We also encouraged respondents to describe any additional changes in an "other" category.

As shown in Table 13.26, the changes that we asked about were not widespread. The most prevalent of the three changes noted above was the transfer of the before- and after-school program

Table 13.25

Changes to Youth Program in Response to MCCA, by Service

Service	Percentage	No.
Air Force	48	83
Army	30	57
Marine Corps	38	8
Navy	44	50
Mean	41[a]	198

SOURCE: Data from mail survey.

[a]Means are not significantly different (F-test).

Table 13.26

Specific Changes to the YP in Response to the MCCA, by Service

Service	YP Administers Before- and After-School Program	YP Location for Before- and After-School Program	YP Staff Left for CDC Caregiver Jobs	No.
Air Force	58	6	11	88
Army	23	14	14	69
Marine Corps	8	0	8	13
Navy	33	10	8	73
Mean	38[a]	9	9	243

SOURCE: Data from mail survey.

[a]Means are significantly different: $p < 0.001$ (F-test).

administration to YP. Although 38 percent of survey respondents indicated that administration of before- and after-school programs had moved to YP in response to the MCCA, only 9 percent indicated that these programs had physically moved to the YP center. An Air Force youth director with whom we spoke during fieldwork explained that a shortage of space in the CDC and a very long waiting list for full-day care led to a decision to move the before- and after-school program to the youth center. The move enabled the before- and after-school program to triple in size.

Although there was some concern that youth programs staff might abandon YP for now-better-paying CDC caregiver jobs, our survey data suggest that such movement was not common. Only 9 percent of respondents indicated that there had been any movement of YP staff to such positions as a result of increased caregiver wages under the MCCA.

During fieldwork, we did hear of a few instances in which YP staff had left for CDC jobs. One Navy YP director told us that as a result of the MCCA, YP was now forced to compete with CDP in hiring their before- and after-school program staff. YP regularly loses out, she said, because CDC offers better pay and more hours. A youth director on an Army base concurred. She has found that since the MCCA raised CDC caregiver salaries, YP recreation aides move to caregiver jobs as soon as they open. Another YP director noted that the opportunity to earn college credits through CDC training had

convinced two of her staff to leave YP for the CDC.[14] Said an outspoken Air Force YP director, "It's hard to keep someone you pay $4.25 an hour, provide no benefits, and can't offer full-time work." Nevertheless, she claimed, she had not lost staff to the CDC.

However, in several cases when YP staff left for the CDC, our YP respondent concluded the story by telling us that the prodigal staff member had returned to YP. In a few instances, we were told that the staff member had concluded that the higher pay was more than justified by the harder work (diaper changing was invariably mentioned at this point). Another respondent told us that former YP staffers had trouble with the far more structured setting in the CDCs. She'd had one staff member leave CDP for YP because she found the CDC environment "stifling."

We asked our fieldwork interviewees the same question that we asked survey respondents: Had the MCCA changed the before- and after-school program? A number of respondents told us that the thrust of the MCCA, which was to convert CDCs to the almost exclusive provision of full-day care, had forced the before- and after-school program out of the CDC. In some cases, the program continued under CDP auspices, but in other places the administration of the program had changed as well.

A few YP respondents to whom we spoke during fieldwork were able to describe concrete benefits that accrued to YP from the MCCA. Most of these concerned improved training for CDC caregivers that was also provided to YP staff. For example, on two Air Force bases that we visited, the CDC T&C spec trains before- and after-school program staff. This has improved the quality of that program and has created a cadre of more knowledgeable staff in the youth center. One YP director whose staff receives this training views it as one part of the effort to move the before- and after-school program towards compliance with the MCCA. According to a high-level Pentagon respondent, many of these sorts of efforts have been "preventive strikes" designed to keep Congress from sticking its nose into YP. An Air Force interviewee argued that preventive strikes would not suffice. She warned that YP will not get the funds it needs until it gets

[14]School-age care training modules recently have been developed that include the same 13 competencies as the CDC and FCC ones.

its own equivalent of the MCCA. In any case, such "preventive strikes" are far from universal. A YP director on a naval base we visited told us that the Navy requirement for youth training of 30 minutes a month had not changed.

Some fieldwork interviewees told us that YP had benefited from the MCCA in less concrete but nevertheless important ways. For one thing, these respondents said, the MCCA had underlined the importance of programs for children, the importance of staff training, and the need for vigilance about child abuse. A few respondents wanted to take it farther. Said one, "I would like [YP] to be an extension of child development—equal pay, equal staff training, integrated curriculum (especially for the before- and after-school programs), and as much emphasis on creating buildings and spaces as in child development." This director hoped to benefit from the material and other resources being lavished on child development by having YP become an extension of child development. "We need a playground," she said, "but there is none attached to the new [YP] center. Child development has a two-inch-thick book about playgrounds." A high-level Army officer echoed these sentiments. In his view, the "program break" that now exists between CDP and YP should not be there. He thinks that there should be a continuum, with Youth Services becoming Youth Development Services. This same respondent noted that the MCCA has been helpful to YP in both reinforcing the presence of APF$ in child care programs and giving the force of law to quality standards in child care.

But an Army director of community and family activities disagreed. His staff wants a CDP-YP consolidation, but he has vetoed the idea out of concern that "excessive" CDP regulations might be visited on YP if they were one program.[15]

A savvy YP director on another installation that we visited has used all the attention that CDP has received to help her program. "The MCCA has made them [commanders] sit up and take notice [of CDP]." In her view, they need to pay attention now to YP. She believes that on her base, this message has been conveyed to and

[15]Since our data collection period, the Army has implemented such a consolidated system.

heard by command—she doubts they would have their brand-new youth center facility if someone high up had not been interested.

A high-level Army officer at headquarters validated her view. "As I understand it, it [the MCCA] does not directly pertain to YS," he said, but MCCA goals have led him to point YP in a developmental direction. "The same public pressure [to improve the quality of care and reduce the possibility of child abuse] that led Congress to pass the MCCA remains there, and is pushing YA."

In a few cases, YP staff were attempting to emulate the MCCA; mostly this occurred in the context of before- and after-school programs, which most closely resemble CDPs in terms of parental expectations for fairly close supervision. An Air Force YP staffer told us, for example, that in the before- and after-school program on her base, they were allowed to have 18 children per staff member. But staff had decided to move the program more "into" the MCCA mode by trying to keep that ratio closer to 15:1.[16] One YP director told us that the part-day enrichment program at the youth center had been accredited at the same time as the CDC.

At the same time, as our survey data suggest, most fieldwork interviewees reported that there had been no changes to their youth program as a result of the MCCA. The lack of change was brought home on one installation that we visited, where the CDC director we interviewed did not know the YP coordinator's name. A few respondents clarified for us that the lack of change in YP that we found in our survey data was really a lack of *positive* change. Several fieldwork interviewees noted that YP, always in a less favored position than CDP, had suffered further as a result of the MCCA because far more APF$ were going to CDP than before. One CDP administrator described YP as a "time bomb;" a program that had gotten worse since the MCCA. Moreover, so much time had been required to launch MCCA implementation that there was little time or energy left for YP. This led, on one installation, to a deterioration in the relationship between YP and child development.

An Army YP head told us that she feels she is always competing with providers of preschool care; usually, she loses. With the

[16]The Air Force staff-to-child ratio is now 1:12 for all ages.

MCCA's funding scheme, the installation is required to match parent fees with appropriated funds, so CDP is "naturally covered." Her own budget has declined but CDP's budget has expanded enormously. She said that she could not get $19,000 for sand for her playground because of the huge amount of money going to CDP. She told us how disappointed she was that YP had not been included in the MCCA. This same respondent told us that parents often asked her why YP did not have their own MCCA. A Marine Corps colleague echoed her sentiments. This YP director described command as very supportive of youth programs, but acknowledged that there was competition with CDP for funds. Then she corrected herself. "Actually," she said, "we *don't* compete; CDP gets the money." Her program no longer gets APF$, but APF support for CDP has mushroomed since the MCCA. She worries that teens on her isolated base need more than just a recreation program, but she does not have the funds to do more. She believes that older kids are just as important as babies and preschoolers, but they do not receive the same kind of attention or support. "All of the kids are important, but the needs of the older ones are not being met because of [lack of] funding."

An Air Force colleague agreed. The focus on newborns to five-year-olds has left six- to twelve-year-olds in poor facilities with poorly trained staff, he said. A Marine Corps YP director said that her relationship with CDP staff had deteriorated since passage of the MCCA. She was tired of hearing about how much money CDP was getting. An Air Force colleague concurred. "The act resulted in some bad feelings between CDP and YP. Some people in YP feel 'we're not important enough to be regulated.'" CDP responses exacerbate the problem in some places. "They think they're better than we are," she added. "The differences in regulation contribute to parental unhappiness," she continued. "Parents come over here [to YP], people who have been in child development, they have the perception that we're not doing things right." At the same time, she noted, there is some halo effect—CDP was *so* good, some parents say, we'll go ahead and try the older kids' program, because it is part of the same organization.

There was another group of fieldwork interviewees for whom the MCCA had pressed alarm buttons. They believed that the passage of the MCCA presaged the passage of a similar bill for youth. One high-

level Pentagon respondent told us that the major effect of the MCCA on YP was that it made "some segments wary that we'll be getting some direction [in YP] as in a Military Youth Act of 199__."[17] A MACOM YP manager appeared to represent one of those segments. He told us that he had been moving YP in a more developmental direction for the last five or six years. The MCCA galvanized these efforts. He tells installation commanders that YP is a "monster sleeping, which shouldn't be woken up." What he means by this is that they should put more money into youth services now to avoid the [child abuse] scandals that occurred in CDP. Such scandals resulted in the MCCA; he did not want such an act for YP. One policy he had initiated to stave off problems required six- to eight-year-olds to be in organized classes at the youth centers; they could not participate in open recreation. In fact, the relevant policy in this major command states that if a child in this age range remains at the center more than 30 minutes after a class ends, the military police are to be called.[18]

Although a few respondents were pleased by the prospects of APF$ and other benefits if a youth bill were to pass, most of the people who mentioned this possibility were distinctly negative. They believed that a Military Youth Act might bring appropriated funds largesse, as it had done for CDP, but they were unwilling to pay the price of much stricter regulation that they believed inhered in the benefits. These people generally believed that YP had a distinctly different mission than that of CDP—that they were there to provide recreational opportunities to kids who had spent most of the day in school. Consequently, they much preferred to provide their young charges with a range of recreational options (and sometimes other options as well, such as homework rooms) and allow the kids to make choices about how they spent their time. They contrasted this with the carefully planned developmental curricula that define the delivery of services in the CDCs.

One such person was a Marine Corps YP director. She told us that it "raises her hair" when YP is associated with CDP or called "day care,"

[17]These perceptions may have changed since the realignment in the 104th Congress, but we do not have the data to address this.

[18]The Air Force has issued school-age program standards since our fieldwork.

because it changes parents' expectations. With day care, parents want low ratios and increased accountability, all of which "gets in the way of recreation," she said. An Air Force YP director concurred that differing levels of regulation between CDP and YP create problems. There is "a view in some quarters" that child development provides better programs, but this view is based on their stricter regulations, she said. "People don't understand the difference between what they're doing and what we're doing. We don't speak in hushed tones. We're not a hands-on program—YP is not designed to provide direct supervision of children." An Army officer concurred with this assessment but in less positive terms: "Kids in YS (and not in SALK programs) are largely unsupervised."

Ironically, some of the very people who opposed the idea of greater scrutiny for YP noted that the MCCA, in raising the specter of a youth law, had actually improved youth programs. In these cases, YP directors had often used the MCCA as a stick to enforce increased compliance with existing regulations.

A number of fieldwork interviewees told us of other changes to YP, changes that had not occurred in (direct) response to the MCCA. One of the most important and salutary was the Air Force decision to move both CDP and YP under a Youth Support Flight Chief, a change that reflected a similar consolidation of both programs under a single individual at Air Force headquarters. At the time of our fieldwork, this change had not been made at all installations, but where it had, it was having an effect on YP.

At one Air Force installation that we visited, the change had resulted in increased attention and support to YP. According to the youth director there, parent surveys indicate that the perceived quality of youth programs has also increased since the reorganization. When YP was under recreation services, money that might have gone to YP went instead to the gym or the bowling alley. Under the Youth Support Flight Chief, children now have someone who negotiates with the commander who is solely concerned with children and youth. This place at the table led to a $100,000 infusion of resources into the YP budget on his installation.

At another Air Force base, the consolidation under the Youth Support Flight Chief meant that child development trainers would now

be working with YP staff as well. An Air Force YP director at the major command level told us that since the CDP and YP were reorganized under the Youth Support Flight Chief, we are "one big happy family." Satisfaction has increased because the new structure conveyed to YP directors that they might expect more APF$ within the next year or so.

CONCLUSIONS

The MCCA was designed to correct a number of problems that existed in CDCs at the time of its passage. For the most part, the legislation and regulations have been very successful in doing so. Our data indicate that CDC quality has improved; the quantity of care has increased as well. In addition, the changes that have occurred have decreased the variability across CDCs, another MCCA goal. Moreover, policy changes have followed from the MCCA implementation effort that will ensure the stability of these improvements. A universal accreditation mandate, consolidation of CDP and YP on Air Force and Army bases, and expansion of CDC training requirements to FCC are all mechanisms to reinforce quality in CDCs and expand the reach of the MCCA to other child- and youth-serving components.

Limited data suggest that the MCCA's effect on FCC has been salutary. An FCC monitor, supported by APF$, has provided FCC with much-needed resources and stability. Modification of the CDC training modules for FCC has improved professionalism and the quality of care.

Effects on YP have been more mixed. The MCCA precipitated a small amount of change in these programs, but those changes were far from widespread or solid. Lack of change in YP reflects lack of YP focus in the legislation and the absence of a *system* of services for children and youth. At the same time, the MCCA's focus on CDCs reduced the relative level of support for YP. This was evident in both perceptions and in the flow of dollars and other resources to these programs. Some were able to exploit MCCA concerns about kids on behalf of YP and were optimistic that YP would soon benefit more directly, but for most others, their second-class status had been reinforced by the act and its sequelae.

Chapter Fourteen

CONCLUSIONS AND RECOMMENDATIONS

The MCCA has been an extremely effective tool for improving CDC quality. Improved quality everywhere has dramatically reduced the substantial quality differences across CDCs and installations that existed before its passage. Athough the effect has been more modest, the MCCA has also resulted in an increased number of child care slots, according to survey respondents.[1]

The difficulty of the implementation process varied substantially across provisions and services. Those provisions whose implementation process was structured in the law and that included deadlines or monitoring provisions, e.g., inspections, were more easily and fully implemented. Those that threatened CO autonomy, lacked a deadline, or were more ambiguous (e.g., APF$ match) were implemented more slowly and sometimes less completely.

The effects of the MCCA extended well beyond the CDCs that were the focus of implementation efforts. In particular, the FCC program expanded and became more professional. Perceptions of its value increased as well. Effects on YP were evident but far more mixed. In some cases, the MCCA has had a salutary effect on YP; in others, the effects have been less positive.

Our study of MCCA implementation also revealed a number of strengths and problems in the delivery of military child care. Below, we list our recommendations for ways to build on the enormous progress that the MCCA brought about and to continue to move to-

[1]Drawdowns during the study period reduced the number of slots available.

ward a system of child care that meets the needs of children, families, and the military.

Our recommendations span a wide range of the child care enterprise and vary from rather specific points to far more global ones. We were mindful in making them that each must be capable of being implemented within the boundaries created by the MCCA; efforts to revise the law would be both difficult and counterproductive at this time.

We begin with the larger, more systemic recommendations that seem closer to the heart and spirit of the MCCA and its goals and move down the list, ending with the most specific ones or those that are more peripheral to the act. One can certainly argue about the characterization of these recommendations in this way; we readily acknowledge that the ordering is somewhat arbitrary.

MORE CLOSELY INTEGRATE YOUTH PROGRAMS

As the report discusses and documents, child development programs have benefited enormously from the increased scrutiny and resources that have resulted from the MCCA. But the report also documents that, with only a few exceptions, youth programs have been excluded from the benefits that child development has received. This is particularly the case in the Navy and Marine Corps. Indeed, many of our respondents believe that YP has suffered relatively or absolutely from the increased amounts of attention and resources that have flowed into child development programs since the passage of the MCCA. In both the Army and Air Force, attempts have been made to extend child care concerns to YP by bringing YP under joint children and youth oversight at the HQ and installation level.

For a number of reasons, the situation should be remedied and youth programs given more scrutiny and resources. First, youth programs are not meeting the many and diverse needs of school-age children. Recreation is certainly important, but school-age children need many other things as well, including homework support, social activities, and information and education about a range of topics.

Second, older children deserve as much concern from the military about their developmental needs as younger ones do. This message of concern is not now conveyed and has in fact been undermined by the enormous effort that has gone into an MCCA implementation process focused on CDPs.

Third, because of the focus on increasing availability of full-time slots in CDCs, growing numbers of the youngest children now attend before- and after-school programs that have been moved out of CDCs and into YP facilities. There is widespread agreement that these children need more supervision than YP facilities are staffed or resourced to supply.

Finally, child care in CDCs is just one part of military child development programs. These programs include CDCs, FCC, school-age care, and hourly care. In earlier work (Zellman, Johansen, and Meredith, 1992; Zellman and Johansen, 1995), we question whether these elements cohere into a system of care. What is clear is that the current "system" does not extend to YP.

It should. YP needs more APF$, more scrutiny, and an expanded mission that includes recreation but is not limited to that aspect of school-age children's developmental needs. These elements would make YP a safer, more growth-enhancing environment for children and would enforce the message conveyed during the preschool years of the importance of developmentally appropriate care to children's growth and well-being. In one site that we visited, staff in YP talked about creating a "youth development program" that would have the resources and mission to address socio-developmental needs as part of a larger system of child development.[2] Such a program, organized and run in a way that maximizes both interaction with CDP and the power of natural youth advocates, as discussed below, would better serve children, would communicate to parents that the military's concern for their children does not stop at age five, and would address the obligation to families that the military has accepted in return for their commitment to putting the military mission above all.

[2]We encountered a program of this name on one installation that we visited, but its scope is not as broad as what we envision here.

EQUALIZE FAMILY CHILD CARE TO THE EXTENT POSSIBLE

FCC experienced a key benefit from the MCCA in the form of an APF$ supported GS program monitor position on each installation with an FCC program.[3] In many cases, this position and its occupant has energized and dramatically improved the program. Nevertheless, implementation of the act focused heavily on CDCs. This focus reinforced FCC's lesser status in the child development system, a status that reflects commander and parent concerns about limited opportunities for scrutiny, substantial subsidy of CDCs that results in low fees there, and very limited use of authority to directly subsidize FCC providers to equalize fees.

The Army and Air Force did take advantage of the MCCA and its sequelae to introduce several changes in FCC that have improved both its performance and its status. In particular, the Army funds some portion of a T&C spec position as part of each FCC program, with the percentage FTE dependent on program size. The Air Force had T&C specs turn their attention to FCC and programs for school-age children once it had accomplished almost universal accreditation of CDCs. This resource provides FCC both with the image of being focused on training and quality and the reality that providers can and do benefit from the presence of a well-educated and well-trained person who is devoted to improving program quality. We suggest that comparable resources be a part of the FCC program in each service.

The services have also established policies that FCC providers undergo the same or equivalent training as CDC providers to participate in the FCC program.[4] This policy has a number of advantages for providers and for the children and families who use the program. First, equal training establishes in FCC an expectation of quality that is equivalent to that in the CDCs. Although the limited scrutiny issue cannot be overcome because of the nature of FCC care, any obvious means to increase quality diminishes concerns about lack of scrutiny. Well-trained providers who have a commitment to provid-

[3]Such monitors were in place in some locations in some services before the MCCA, e.g., the Air Force had GS monitors in some locations as early as the 1980s.

[4]A set of FCC-specific training modules was developed by the DoD. These modules are similar in content to the CDC modules but are specific to the FCC environment.

ing high-quality care, as evidenced by their willingness to undergo training, instill more confidence in parents who may be worried about what goes on in FCC homes.[5] Second, equal training enables FCC providers to move far more easily between FCC and CDC positions. This creates a stronger sense of a career in caregiving to young children. In addition, the system is less likely to lose caregivers altogether if they must move or change the locus of their work.

Finally, we strongly urge far more widespread use of the subsidization authority permitted under the MCCA.[6] Direct subsidies maximize the advantages of FCC to the system in several ways. First, as we argue in our 1992 report, the substantial subsidization of CDCs in the absence of subsidies for FCC care result in higher fees in FCC. This serves to increase parental preferences for CDC care, reinforcing in most cases a preexisting preference based on the attractiveness, perceived safety, and stability of CDCs. Direct subsidies would serve to decrease the extra costs to parents associated with FCC care. This would make this care more attractive and might reduce the numbers on waiting lists, since some portion of those on waiting lists are there because they prefer CDC care to the FCC care that they are receiving.

An active subsidization program would also help to open slots to infants, the parents of whom have the hardest time finding care. Lower staff-to-child ratios for infants in both CDCs and in FCC create disincentives to provide such care in both locations. In CDCs, little can be done to deal with the consequently higher costs of providing care to infants, since fee schedules do not vary as a function of child age, as they typically do in civilian programs. As a result, many CDCs, in an effort to reduce costs and open more slots, have moved infants out of centers.

In contrast, much can be done to deal with the increased costs of providing care to infants in FCC. Providers can and have raised their fees for infant care, for one. But this undermines the goal of afford-

[5]An accreditation program for individual FCC providers is in joint development by the Army, Navy, and Marine Corps. The Air Force is also involved in this issue, through an existing civilian accreditation program. Accreditation should help to improve real and perceived quality of FCC care.

[6]Since our data collection period, the Navy and Marine Corps have begun to actively subsidize FCC care, which represents a dramatic policy change. The Marine Corps has targeted subsidies to infant/toddler, hourly, extended hours, and special needs care.

able care for military families. And it creates special problems because the parents of infants are often the lowest-ranked personnel. The other, preferred alternative is to provide direct subsidies to those who provide care to infants. This subsidization would allow CDP staff to set FCC infant care rates at a level that is affordable to young families, would enable providers to make a reasonable wage while still caring for infants, and would therefore increase the supply of infant slots.[7]

Finally, there is evidence that subsidies work in promoting the above outcomes. The subsidy test authorized in the MCCA demonstrated that subsidies have a substantial effect in opening slots to infants and increasing the number of FCC homes. For these reasons, we strongly urge expanded use of FCC subsidy authority.

We also encourage support for backup care and vacations. Direct provider subsidies increase supply, but support for respite and vacation care is likely to increase the reliability of the system. The latter is important since many parents reject FCC care because they view it as unreliable, depending as it does on single providers. Backup and vacation support would increase real and perceived reliability. We urge more active support of subsidization of FCC providers for all of these reasons. One way to increase support would be to require that guidelines for their use be developed in each service.

INCREASE COORDINATION AND NETWORKING WITHIN THE CHILD DEVELOPMENT SYSTEM

Like providers of most services, those who manage and deliver child care in CDCs and in FCC report a sense of isolation and a feeling that they are confronting problems that have been solved elsewhere. This need not be the case for those who deliver child care in the military. A strong, potentially unifying system there could and, in our view, should use its resources to help those delivering child care feel more

[7]When FCC providers are receiving a direct subsidy, child development managers may exercise far greater authority in setting FCC fees.

connected and benefit from the ideas and hard work of others in the system.[8]

Given downsizing and reduced resources, increased coordination takes on greater importance as a means of reducing the redundancies that occur when the four services separately oversee CDPs that may be located in close proximity.

We suggest that more coordination be adopted as a valuable system goal that could be achieved with minimal cost or difficulty. Regional cross-service training represents an opportunity to achieve efficiencies that could compensate to some degree for lack of new resources. In many cases, the close proximity of CDPs sponsored by different services would facilitate such networking. The decreased variability in child care quality that resulted from the MCCA makes such a notion far more feasible than it might have been in the past.

Key to the success of such efforts is building in an expectation that networking should occur, that certain individuals or offices are responsible for ensuring that it happens, and that people throughout the system are expected to be available to each other to share their experiences and their expertise.

At the installation level, networking among FCC providers would also be very advantageous. Again, this networking would benefit individual providers and contribute to perceptions that FCC is part of the child care delivery system. Some of the recommendations above—for subsidization of respite and vacation care—would indirectly promote such networking among FCC providers.

CONSOLIDATE RESPONSIBILITY FOR CHILDREN'S PROGRAMS

On several of the Air Force bases that we visited, we spoke with the Youth Support Flight Chief, who was responsible for overseeing both child development and youth programs. This position, new in the places we found it, provided children and children's programs with a

[8]The DoD has promoted a number of coordination activities, including joint service CDS and YP manager meetings. Joint training materials, discussed above, also contribute to increased coordination.

single person who could advocate these programs within MWR. Moreover, with responsibility for children's programs vested in a single individual, there was far greater potential for these programs to be seen and treated in a less competitive, more comprehensive way.[9] FCC may also benefit from this new structure. On one base that we visited, FCC had been taken out of the CDC structure and is now directly supervised by the Youth Support Flight Chief, giving this program a stronger voice. We urge those who run child development and youth programs to support the development of such a position on each installation.

Respondents everywhere told us that the more attention that child development programs get from the commanding officer, the better they fare. On one installation that we visited, a developmental assessment team meets quarterly with the commander. Members of that team to whom we spoke told us that the team was effective because it had the commander's ear, a rare opportunity for CDP on the installations that we visited. In these meetings, the team could advocate children's needs. Such teams have a great deal of potential and should be encouraged.

PROMOTE UNIVERSAL ACCREDITATION

RAND's 1994 report on accreditation concluded that accreditation improves the quality of care provided in CDCs, not only in those centers with lower pre-accreditation quality of care but also in initially high-quality centers. Further, many aspects of the MCCA, including the inspection program, increased caregiver training and salaries, and the hiring of T&C specs, have substantially reduced the incremental costs of accreditation. Consequently, we concluded in our 1994 report:

> Given minimal incremental costs for accreditation and substantial apparent benefits, we conclude that universal accreditation of CDCs is a desirable and achievable goal. Indeed, as accreditations are achieved by initially less-able CDCs, we have every reason to expect that the benefits of accreditation for military children will become increasingly apparent.

[9]The Army has also achieved such a consolidation since our data collection period.

As our 1994 report notes, both the Air Force and Army had already adopted universal accreditation policies at that time. Since then, the Navy and Marine Corps have also adopted universal accreditation policies. We support these policies and their rapid implementation.[10]

CREATE A GS CAREGIVER SERIES AND SPECIFIC QUALIFICATIONS

At the time of our survey and visits, it continued to be difficult to hire GS staff. A major reason for the difficulty was the lack of a designated series and specific qualifications for caregivers in the GS system. Lack of such a series caused both inefficiencies and, at times, a poor fit between new recruits and the demands of caregiving jobs. Poor fits often resulted in higher turnover, as people who did not really wish to be caregivers used the position to move up in the GS system. Before they did so, they probably provided less than optimal care to the children in their charge.

We recommend that the DoD take on the task of creating a caregiver series and specific qualifications in the GS system so that those who wish to pursue caregiving jobs—or to avoid them—can do so within that system. This will increase recruiting efficiency, reduce turnover, and better serve both children and job seekers.

INCREASE FLEXIBILITY IN USE OF APF$

Difficulties hiring into GS positions had left many CDCs at the time of our fieldwork with a significant amount of unspent APF$. The large amounts of money focused new attention on a problem that needs to be addressed: rigidities in how APF$ may be spent. The deadline for reimbursement of NAF with APF$ speeded the conversion of NAF positions. By December 1991, all services except the Marine Corps had reached their GS hiring and conversion goals. There is a much stronger sense that people now understand the need for GS positions and have largely resolved the staff morale problems associated with early GS hires and conversions.

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[10]The 1996 Defense Authorization bill (P.L. 104-106) mandates accreditation.

An argument could be made at this point that reinstatement of reimbursement authority is justified, at least in CDP, particularly if monitoring of hires is in place. This authority would increase flexibility and allow CDP managers to use limited resources far more efficiently.[11]

INVESTIGATE THE PROCESS OF OBTAINING BACKGROUND CHECKS

Although background checks are not a part of the MCCA, complaints about the length of time to complete them and the tendency to assume that they are a MCCA provision were so widespread that we felt compelled to address them in this chapter.

We did not analyze the process of obtaining background checks in enough detail to make specific recommendations about them. But we did learn that they are enormously time-consuming, rather costly, and a major factor in CDC hiring delays and vacancies. (See Chapter Eight for data on these delays.)

Consequently, we recommend that the DoD investigate the process through which background checks are requested and obtained and whether the relevant actors on local installations understand the system adequately. For example, many of the people whom we interviewed seemed to think that all checks needed to clear before work could begin, when in fact, only the local checks must be completed and returned before work can commence; other checks need only be initiated by then. The goal of this investigation, which would follow on its 1992 effort, would be to assess whether and how the process can be streamlined so that background checks no longer represent a significant obstacle to the smooth functioning of CDCs. It would also focus on assessing people's understanding of the system. If there are inaccuracies, as we suspect, steps should be taken to correct misperceptions.

[11]Congress has authorized a test of a "unified workforce," which includes APF to NAF reimbursement, during FY97–98.

CONSOLIDATE PARENT BOARDS

The MCCA's effort to involve parents in the operations of the CDCs that their children attend is laudable. However, the effort is being undermined in some locations by the existence of separate boards for each program, e.g., full-day care, part-day care.

Our fieldwork data suggest that parents who send their children to part-day programs are more likely to be actively involved in the CDC. This is no doubt because they have more time to do so, as it is rare for both parents of children in part-day programs to work full-time. In contrast, when both parents work full-time, they have limited time and energy to devote to a parent board. In addition, there are often class differences in the families who send their children to part- rather than full-time programs. These differences are exaggerated when separate boards exist for each.

We strongly urge that there be one unified parent board on each installation. A unified board will speak for all children and parents and will be more likely to do so in a loud, clear voice.

Appendix

THE MILITARY CHILD CARE ACT OF 1989

The Military Child Care Act of 1989 was passed by both the House and Senate in November 1989. The goal of the MCCA was to improve the availability, management, quality, and safety of child care provided on military installations. Its major components include:

- *An increase in the military's mandated contribution to the operation of child development services, to a 50 percent match between appropriated funds and parent fees.*[1]

This provision increases funds for some services but not for others. Priority for use of these funds should go to increasing the number of child care employees who provide direct care to children and to expanding the availability of child care. Other uses of funds are unlikely, since that would require special approval from the Secretary of Defense.

- *The development of training materials and training requirements for child care staff.*

Centers must designate an employee responsible for the delivery of training and oversight of employee performance. This provision appears to address widespread Congressional concern over the quality of child care programs.

- *A pay increase for child care employees directly involved in providing care.*

[1]The match applied only to FY90 but has been continued under DoD policy.

This provision compensates CDC caregivers at rates equivalent to that of other employees with comparable training, seniority, and experience on the same military installation.

- *Employment preference for military spouses.*

Military spouses are given priority for hiring, or promotion within, the position of child care employee.

- *The addition of child care positions.*

Competitive service positions (3,700) are to be made available in the DoD for child care personnel. These positions may be filled by employees involved in training and curriculum development, child care administrators, supplemental care administrators, child development center directors, or family day care coordinators.

- *Uniform parent fees based on family income.*

This change addresses the goal of making child care more affordable to lower-ranked military personnel.[2]

- *Expanded child abuse prevention and safety.*

The MCCA directs the Secretary of Defense to establish and maintain a special task force to respond to child abuse allegations and to establish and maintain a national child abuse and safety hot line that accepts anonymous calls. The legislation calls for four unannounced annual inspections with needed remedies to be made within 90 days, unless this requirement is waived by the Secretary.

- *Parent partnerships with CDCs.*

A board of parents at each military CDC is to be established at each center. Parent participation in the centers' programs is encouraged with reduced fees.

- *Report on five-year demand for child care.*

The law instructs the Secretary of Defense to issue a report on the five-year demand for child care six months after passage. The report

[2]The fee structure later came to be based on *total* family income.

should include a plan for meeting demand and a description of methods for monitoring family day care providers.

- *Subsidies for family home day care.*

Appropriated funds may be used to provide assistance to family day care providers as a means of providing these services at the same cost as CDC care.

- *Early childhood education demonstration program.*

Fifteen percent (about 50) of the military child development centers are to be accredited by "an appropriate national early childhood accrediting body." These centers will be designated as early childhood education programs and will serve as models for CDCs and family home day care. The law also specifies that an independent body evaluate the effects of the accreditation on children's development.

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